Fighting Overcharged Bills from Predatory Hospitals

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"Liberty for wolves is death to the lambs." Isaiah Berlin

I. INTRODUCTION

Hospitals routinely expect patients to pay different prices for the same services and often ask the most vulnerable patients to pay ten to twenty-five times as much as the hospital routinely accepts as payment in full. For a service that the government allows participating hospitals to charge its patients $117 in 2019 dollars, some hospitals may charge patients up to $3254 for the same service,[1] and most hospitals charge almost $500 for that same $117 service.[2] Excess hospital charges or "markups" pose a significant financial burden (including frequent bankruptcies) on uninsured and out-of-network patients and cause some people to avoid necessary emergency or urgent care leading to unnecessary deaths and disabilities.[3] Vulnerable

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1. Tim Xu et al., *Variation in Emergency Department vs Internal Medicine Excess Charges in the United States*, 177(8) JAMA INTERNAL MED. 1139, 1140–41 (2017) (finding that hospitals charged "excess charges" up to 27.7 times the Medicare allowable for emergency room physician interpretation of computed tomography (CT) scans of the head (Code 70450)); *Physician Fee Schedule Search, Code 70450, CT Head/Brain w/o Dye*, CTRS. FOR MEDICARE & MEDICAID SERVS., https://www.cms.gov/apps/physician-fee-schedule/search/search-results.aspx?Y=0&T=0&HT=0&CT=0&H1=70450&M=1 (click "Accept" at bottom of page) (website protections preclude archival URL) (showing the current allowable facility charge is $117.49 on September 22, 2019). Doing the math, *27.7 times $117.49 = $3254*.

2. Xu et al., *supra* note 1, at 1142 (noting "[i]n considering all ED services, for every $100 in Medicare-allowable amounts, different hospitals charged patients . . . a median of $420 (markup ratio, 4.2)" and noting that some charged $1260 for the same services). So, the median price would be *4.2 times $117.49 = $493.46*.

3. Xu et al., *supra* note 1, at 1140 (footnotes omitted) ("Excess charges, or 'markups,' on medical services can impose a significant financial burden on uninsured and out-of-network patients. Medical bills are the leading cause of bankruptcy and contribute to some patients electing to avoid necessary care.").

patients in times of crisis enter a hospital believing they are in a safe haven—similar to Little Red Riding Hood entering her Grandmother's house; however, waiting inside the hospital is a billing machine ready to pounce with a life-crushing, overcharged medical bill that would make the Big Bad Wolf blush.[4] Predatory hospital bills exploit people in their most vulnerable state (during a medical crisis) and ruin lives, hopes and dreams by creating financial disaster—sometimes even from relatively minor physical injuries.

In one example, Jeannette Parker's compassionate attempt to help a hungry stray cat led to a hospital bill of $48,512 to treat a minor cat bite.[5] Because it was after normal business hours, and she was potentially exposed to rabies—which can be fatal—Jeannette had no choice but to go to the local emergency room and trust that she would be treated fairly; in other words, she was vulnerable and at the mercy of the local hospital.[6] The CDC estimates that 40,000 to 50,000 people annually get rabies treatments, which cost over $3000 on average *for the whole course of treatment* of four doses of vaccine over two weeks—yet Jeannette's bill was over $46,000 for the first dose of the medication alone.[7]

You might think Jeannette's experience is unique—it's not.[8] At the heart of the problem are often arbitrary and capricious hospital "chargemaster" charges (a.k.a., "list prices") that have almost no basis in realistic

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4. *See generally Little Red Riding Hood*, AM. LITERATURE, https://americanliterature.com/childrens-stories/little-red-riding-hood [https://perma.cc/62G9-2MYY] (telling a children's fairy tale in which a small girl is devoured by a crafty wolf dressed in her grandmother's clothing).

5. Julie Appleby, *Cat Bites the Hand That Feeds; Hospital Bills $48,512*, NAT'L PUB. RADIO (Feb. 26, 2019, 5:03 AM), https://www.npr.org/sections/health-shots/2019/02/26/697786766/cat-bites-the-hand-that-feeds-hospital-bills-48-512 [https://perma.cc/L4QS-NM6K].

6. *Id.*

7. *Id.* (noting that (1) "[e]ach hospital can set its own prices for treatment," (2) the drug is made by three manufacturers, and (3) the drug is not involved in any shortages; also noting that the average wholesale price for Jeannette's unexplained, very large dose was $4335).

8. *See, e.g.*, Colomar v. Mercy Hosp., Inc., 461 F. Supp. 2d 1265, 1268 (S.D. Fla. 2006) (reporting patient was billed $12,863 for treatment with respiratory therapy, oxygen, and steroids over a stay of approximately 26 hours); *In re* N. Cypress Med. Ctr. Operating Co., 559 S.W.3d 128, 129 (Tex. 2018) (noting patient was billed $11,037 for 3 hours of emergency room care involving some x-rays, a CT scan, and being released to go home); Jonathan Skinner et al., *The 125 Percent Solution: Fixing Variations in Health Care Prices*, HEALTH AFF.: HEALTH AFF. BLOG, (Aug. 26, 2014), https://www.healthaffairs.org/do/10.1377/hblog20140826.041002/full/ [https://perma.cc/58HG-HTPN] (finding variations in the Dallas, Texas hospital charges for the same cholesterol test ranging from $15 to $343).

expectations of payment.[9] Hospital "chargemaster" prices are often many times the amounts considered reasonable by Medicare and large insurers.[10]

Americans are rightfully concerned about unreasonably high hospital charges. Almost 70% of Americans are either "very worried" (38%) or "somewhat worried" (29%) about being able to pay overcharged medical bills.[11] In fact, more Americans worry about this issue than transportation costs, prescription drug costs, monthly utilities, rent costs, and food prices.[12] The concern has merit since 40% of Americans reported that "they had received a surprisingly large [medical] invoice within the past year," including unexpected bills for more than $2000 for one in eight of those bills.[13] Medical debt is the most common type of past due bill resulting in someone being contacted by a debt collector.[14] In one poll, over one-fourth (26%) of people reported that surprise medical bills had "caused severe

9. *See, e.g.*, Temple Univ. Hosp., Inc. v. Healthcare Mgmt. Alts., Inc., 832 A.2d 501, 505–06, 509 (Pa. Super. Ct. 2003) (explaining that the hospital's CFO and Treasurer "acknowledged that the Hospital had twelve contracts with commercial insurance companies and that none of those contracts provided for payment at published rates" and that the hospital's expert economist "estimated that the Hospital was paid its full published charges only one to three percent of the time").

10. *See, e.g.*, *Temple*, 832 A.2d at 506 (noting that the hospital's "full published charges represented 300% of the Hospital's costs"); Steven I. Weissman, *Remedies for an Epidemic of Medical Provider Price Gouging*, FLA. B. J., Feb. 2016, at 22, 23 ("In Florida, charge master prices are three to four times the amounts negotiated as reasonable charges with insurers.").

11. Jordan Rau, *Surprise Medical Bills Are What Americans Fear Most in Paying for Health Care*, KAISER HEALTH NEWS (Sept. 5, 2018), https://khn.org/news/surprise-medical-bills-are-what-americans-fear-most-in-paying-for-health-care/ [https://perma.cc/S58H-2XKT] (illustrating in Figure 7 that 38% were very worried about surprise medical bills and an additional 29% being somewhat worried).

12. *Id.*

13. *Id.*

14. CONSUMER FIN. PROT. BUREAU, CONSUMER EXPERIENCES WITH DEBT COLLECTION 21 (2017) (footnote omitted), https://files.consumerfinance.gov/f/documents/201701_cfpb_Debt-Collection-Survey-Report.pdf [https://perma.cc/SFR3-MZ98] ("Medical debt is the most common type of past-due bill or payment for which consumers reported being contacted. More than half of consumers who said they were contacted about a debt in collection noted that it was related to medical debt; this was followed by past-due bills for telecommunications and utilities.").

damage" to their household finances.[15] And medical debt is the cause of over half of U.S. bankruptcies.[16]

In addition to overcharging for hospital services, hospitals often control the amounts charged for doctors' services. A 2018 survey shows that over 36% of doctors "receive their compensation directly or indirectly from a hospital."[17] Therefore, hospitals may often bill for their employed physicians' services using hospital "list prices," expanding the problem to include physician services.[18]

This paper reviews the problem created by high hospital "chargemaster" charges, the state and federal protections already in place for attorneys to use to address abusive hospital billing practices, and potential solutions to solve the problem going forward.

II. HOSPITAL PRICING STRUCTURE

Hospitals bill patients differently based upon their insurance status using a "two-tiered" system. Uninsured and out-of-network patients are billed "chargemaster" rates, also described as "list price" or "full price."[19] In

15. Helaine Olen, *Even the Insured Often Can't Afford Their Medical Bills*, ATLANTIC, (June 18, 2017), https://www.theatlantic.com/business/archive/2017/06/medical-bills/530679/ [https://perma.cc/56PF-NTMX] (also reporting that 44% of American adults report that they could not pay $400 in an emergency without selling off possessions, turning to high interest credit cards, or begging family and friends for help).

16. Melissa B. Jacoby et al., *Rethinking the Debates over Health Care Financing: Evidence from the Bankruptcy Courts*, 76 N.Y.U. L. REV. 375, 377 (2001) ("Nearly half of *all* bankruptcies involved a medical problem."); Dan Mangan, *Medical Bills Are the Biggest Cause of U.S. Bankruptcies*, CNBC HEALTH & SCI. (last updated July 24, 2013, 12:28 PM), https://www.cnbc.com/id/100840148 [https://perma.cc/RHB7-5Z9Z] ("Bankruptcies resulting from unpaid medical bills will affect nearly 2 million people this year—making health care the No. 1 cause of such filings, and outpacing bankruptcies due to credit-card bills or unpaid mortgages, according to new data.").. *But cf.* Kimberly Amadeo, *Medical Bankruptcy and the Economy: Do Medical Bills Really Devastate America's Families?*, BALANCE (last updated May 30, 2019), https://www.thebalance.com/medical-bankruptcy-statistics-4154729 [https://perma.cc/78X2-WKTR] (noting some difficulties with determining the precise percentage of bankruptcies related to medical bills, reporting disagreement among researchers, and highlighting some contrasting studies reporting lower percentages).

17. THE PHYSICIANS FOUND., 2018 SURVEY OF AMERICA'S PHYSICIANS: PRACTICE PATTERNS & PERSPECTIVES 23 (2018) https://physiciansfoundation.org/wp-content/uploads/2018/09/physicians-survey-results-final-2018.pdf [https://perma.cc/6WU7-BJ59].

18. *See id.*

19. George A. Nation III, *Hospitals Use the Pernicious Chargemaster Pricing System to Take Advantage of Accident Victims: Stopping Abusive Hospital Billing*, 66 DRAKE L. REV. 645, 649 (2018) (comparing "excessive chargemaster-based list price" to the "contract rate" or "discounted rate").

contrast, Medicare patients, Medicaid patients, and privately insured in-network patients are billed at predetermined contractual rates in line with the reimbursements that hospitals reasonably and customarily expect to be paid.[20]

A. "Chargemaster" Rates: Uninsured and Out-of-Network patients

Each hospital maintains a master list of the "list prices" for all of its goods and services that is known as the "chargemaster."[21] Chargemaster charges are determined unilaterally by the individual hospitals and are not driven by market forces.[22] Chargemaster charges generally have "lost any direct connection to costs or to the amount the hospital actually expect[s] to receive in exchange for its goods and services" because "[f]ew patients today ever pay a hospital's full charges"—actually fewer than 5%.[23] One author writes, "[i]n the healthcare industry, list prices are phony, having no relationship to either costs or value."[24] Some argue this makes them "truly arbitrary and capricious."[25]

However, hospitals often still try to collect the full chargemaster charges from uninsured patients or out-of-network patients, frequently employing liens and other legal mechanisms.[26] If the patient debtor does not repay the

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20. *In re* N. Cypress Med. Ctr. Operating Co., 559 S.W.3d 128, 132 (Tex. 2018) (describing the "'two-tiered' healthcare billing structure" with "reimbursement rates for patients covered by government and private insurance" being substantially different from "chargemaster rates").

21. Nation, *supra* note 19, at 659 (describing hospital chargemaster prices as list prices); Zeynal Karaca & Brian Moore, *Geographic Variation in Hospital Inpatient List Prices in the United States, 2013*, NAT'L CTR. FOR BIOTECHNOLOGY INFO. (Aug. 2016), https://www.ncbi.nlm.nih.gov/books/NBK390482/ [https://perma.cc/ST2R-SY76] ("[E]ach hospital has a chargemaster that contains the hospital's own list prices.").

22. Nation, *supra* note 19, at 660 ("Chargemaster prices are not derived from market forces; rather, they are set unilaterally by the hospital.").

23. *In re N. Cypress Med. Ctr. Operating Co.*, 559 S.W.3d at 132, 134 (also noting that payments that the hospital "actually received for its services were relevant to the reasonable value of those services"—especially since the hospital "rarely recovers its published rates"); Nation, *supra* note 19, at 658–59, 665, 681 (observing that chargemaster prices "bear no consistent relationship" with the "amount a hospital actually receives in payment" for its services; and reporting that "hospitals actually collect their full chargemaster rates from less than 5[%]of their patients").

24. Weissman, *supra* note 10, at 23.

25. Nation, *supra* note 19, at 658.

26. *Id.* at 660–61, 671 (pointing out the fact that "hospitals rarely collect the full amount of their chargemaster list prices does not mean they do not, in certain types of cases, attempt to collect them and in the process cause great harm—even cruelty—to the unfortunate patients who are commanded to pay them"; also noting that a "lien is a claim by a creditor against specific assets of a debtor in order to satisfy a debt").

hospital creditor, the hospital can use the lien to force sale of the patient's assets and collect payment from the proceeds of the sale.[27]

Hospital charges are also extremely variable and unpredictable, which adds to the surprise billing problem—"even among similar hospitals in the same geographic region."[28] On average, "chargemaster prices are more than 300[%] of the amount hospitals actually get paid for their goods and services" and can often be "in excess of 10 times the Medicare allowable cost."[29] The unpredictability of chargemaster charges extends to different procedures in the same hospital because some hospitals might charge as much as 27.7 times the average Medicare allowable for a doctor to read a head CT scan, but "only" charge 7 times the average Medicare allowable to suture up a bad cut (i.e., "laceration"). [30] The arbitrary and unpredictable nature of the chargemaster charges is also evident due to the lack of a relationship between charges and quality of care provided by the hospital.[31] Traditionally, hospitals considered their chargemaster charges to be proprietary and usually kept them secret, except to the patient who received a bill.[32]

Recently, the Centers for Medicare and Medicaid Services (CMS) suggested that the first steps toward increased healthcare price transparency include giving patients access to data and presenting the information with consumer-friendly tools to theoretically allow patients to make informed decisions about their healthcare. [33] Some have argued, "[h]ealthcare is unaffordable because providers are lawfully permitted to shield themselves from price transparency and, hence, price competition."[34] With regard to

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27. *Id.* at 671 ("If the owner does not repay the lender as promised, the lender can, pursuant to the lien, force a sale of the [specific assets] and receive repayment of the loan from the proceeds of the sale.").

28. *Id.* at 658; *see also* Karaca & Moore, *supra* note 21 (noting that hospital charges vary widely across hospitals and markets and are extremely unpredictable).

29. Nation, *supra* note 19, at 680–81; *see also* Xu et al., *supra* note 1, at 1139, 1142 (reporting that nationwide, hospitals charged a median of 4.2 times the Medicare allowable cost and some hospitals charged up to 12.6 times the Medicare allowable cost for emergency department services; in other words, an emergency patient might get a bill for $12,600 for a service paid at $1000 at some hospitals).

30. Xu et al., *supra* note 1, at 1142 (reporting a median markup ratio of 7.0 for laceration repairs and a markup ratio up to 27.7 for reading of a head CT by the emergency room doctor at one hospital).

31. Nation, *supra* note 19, at 658.

32. *Id.* at 660.

33. Seema Verma, *You Have the Right to Know the Price*, CTRS. FOR MEDICARE & MEDICAID SERVS. (Nov. 27, 2018), https://www.cms.gov/blog/you-have-right-know-price [https://perma.cc/DRG6-3K9X].

34. Weissman, *supra* note 10, at 29–30.

price transparency, forty-three of fifty states got an "F" grade in a recent report.[35]

So, starting in 2019, "hospitals are required to establish and make public a list of their standard charges . . . via the Internet"—essentially their chargemaster list must be made available online.[36] In August 2018, CMS issued a final rule (CMS-1694-F) that established new requirements for Medicare-participating hospitals to make their standard charges public.[37] Approximately 3330 acute care hospitals and 420 long-term care hospitals will be affected by this regulation.[38] As of January 1, 2019, the Trump administration is requiring hospitals to publish their "standard charges" online in a "machine-readable" format and update this list at least annually.[39]

Some health care advocates have warned that the new transparency requirement is not as straightforward as it appears.[40] Even if published, chargemaster charges may be difficult to interpret because they "often contain 20,000 to 30,000 individual line items" making it impossible for patients to "calculate the price they will actually owe for the medical procedure they are considering."[41] Many hospitals have posted the data in spreadsheets that contain thousands of procedures (often using medical

35. Meg Bryant, *Some Patients Fight Back Against Surprise Medical Bills*, HEALTH CARE DIVE (July 25, 2018), https://www.healthcaredive.com/news/some-patients-fight-back-against-surprise-medical-bills/526576/ [https://perma.cc/4B49-UFTY] ("An Altarum report from November [2017] gave just two states—Maine and New Hampshire—an A on healthcare price transparency. Maryland and Oregon received a B for their efforts, and Colorado, Virginia and Vermont each got a C. All the rest were graded F.").

36. *Fiscal Year (FY) 2019 Medicare Hospital Inpatient Prospective Payment System (IPPS) and Long-Term Acute Care Hospital (LTCH) Prospective Payment System Final Rule (CMS-1694-F)*, CTRS. FOR MEDICARE & MEDICAID SERVS. (Aug. 2, 2018), https://www.cms.gov/newsroom/fact-sheets/fiscal-year-fy-2019-medicare-hospital-inpatient-prospective-payment-system-ipps-and-long-term-acute-0 [https://perma.cc/2BSK-89DJ].

37. *Id.*

38. *Id.*

39. *Id.* (noting that the updated CMS guidelines "specifically require hospitals to make public a list of their standard charges via the Internet in a machine readable format, and to update this information at least annually, or more often as appropriate"); Robert Pear, *Hospitals Must Now Post Prices. But It May Take a Brain Surgeon to Decipher Them.*, N.Y. TIMES (Jan. 13, 2019), https://www.nytimes.com/2019/01/13/us/politics/hospital-prices-online.html [https://perma.cc/VTG5-TK3T].

40. A. Pawlowski & Lauren Dunn, *Hospitals to List Procedure Prices Under New Law: What You Need to Know*, MSNBC NEWS (Dec. 28, 2018, 10:47 AM), https://www.nbcnews.com/health/health-news/hospitals-list-procedure-prices-under-new-law-what-you-need-n952686 [https://perma.cc/RV3Y-JJLE].

41. Nation, *supra* note 19, at 660.

terminology and abbreviations inaccessible to a lay person), rendering these price lists unusable by patients.[42]

Further, price listings online are often difficult to find due to the CMS's vague requirement only that these prices are published on the Internet.[43] While some hospitals include a link to their charges on their websites' home pages, many hospitals require website visitors to perform a multi-click search to find the price list buried deep within their websites.[44] CMS is still exploring the most effective way to enforce these rules, and there appears to be no timeline for any additional rule-making.[45] More publication and readability requirements are clearly needed to effectively provide consumers with true transparency regarding hospital chargemaster pricing.

Policymakers are already trying to improve transparency requirements. In S. 3592, No More Surprise Medical Bills Act of 2018, proposed by Sen. Maggie Hassan (D-NH), there is a "Requirement For Notice And Consent" regarding pricing.[46] The bill says that for insured patients participating in group markets a provider shall provide to the individual notice

> in the case that such provider is an out-of-network health care provider, [and] obtain from the individual the consent . . . [and

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42. Pear, *supra* note 39 (noting that the posted list prices contain a hodgepodge of medical terms and are difficult for the average person to decode and quoting one consumer as describing the online information as "gibberish, totally meaningless, a foreign language" that was basically undecipherable to a lay person).

43. *Frequently Asked Questions Regarding Requirements for Hospitals to Make Public a List of Their Standard Charges Via the Internet*, CTRS. FOR MEDICARE & MEDICAID SERVS. (Sept. 27, 2018), https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/AcuteInpatientPPS/Downloads/FAQs-Req-Hospital-Public-List-Standard-Charges.pdf [https://perma.cc/5EQ8-ERGR] ("The format is the hospital's choice as long as the information represents the hospital's current standard charges as reflected in its chargemaster.").

44. Harris Meyer, *Hospitals Vary in Publishing CMS Chargemaster Prices*, MOD. HEALTHCARE (Jan. 7, 2019, 12:00 AM), https://www.modernhealthcare.com/article/20190107/TRANSFORMATION04/190109931 [https://perma.cc/95BW-578E] (describing hospitals posting the information "deeper inside their websites, requiring a search and multiple clicks" and one hospital's data appearing only as a "blob of incomprehensible script"); Anne Quito & Amanda Shendruk, *US Hospitals Are Now Required by Law to Post Prices Online. Good Luck Finding Them*, QUARTZ (Jan. 15, 2019), https://qz.com/1518545/price-lists-for-the-115-biggest-us-hospitals-new-transparency-law/. [https://perma.cc/B4Z7-3ZWL] (describing frequent noncompliance with the law and finding that the information was often "buried under many sub-menus or at the very bottom of a long page scroll" for 75% of the hospitals that technically were in compliance).

45. Paige Minemyer, *CMS Looking to Define Enforcement for Its Hospital Price Transparency Rule*, FIERCEHEALTHCARE (Jan. 11, 2019, 8:56 AM), https://www.fiercehealthcare.com/hospitals-health-systems/cms-looking-to-define-enforcement-for-its-hospital-price-transparency-rule [https://perma.cc/E6MS-VEQ4].

46. No More Surprise Medical Bills Act of 2018, S. 3592, 115th Cong. (2018), https://www.congress.gov/115/bills/s3592/BILLS-115s3592is.pdf [https://perma.cc/7U7V-3KKH].

> provide] the estimated amount that such provider will charge the individual . . . in excess of any cost sharing obligations that the individual would otherwise have under such plan or coverage . . . were an in-network health care provider [used instead].[47]

The consent required under this bill would include a

> document . . . signed by the individual . . . not less than 24 hours prior to the individual being furnished such items or services . . . and that . . . acknowledges that the individual has been provided with a written estimate and an oral explanation of the charge that the individual will be assessed for the items or services anticipated to be furnished.[48]

The bill also places limits on balance billing when the hospital fails to comply with the above requirements such that "the out-of-network health care provider may not charge the individual more than the amount that the individual would have been required to pay in cost sharing if such items or services had been furnished by an in-network health care provider."[49]

B. Government and Private Insurer Rates

Medicare and insurance carriers pay rates much lower than chargemaster rates. The Department of Health and Human Services' Centers for Medicare and Medicaid Service sets the rates for Medicare, and insurance companies typically follow Medicare's lead and pay rates based upon Medicare's fee schedules.

Under the Inpatient Prospective Payment System (IPPS), Medicare pays a predetermined, fixed amount for each patient upon hospital discharge depending upon diagnosis; "each case is categorized into a diagnosis-related group (DRG)," and "[e]ach DRG has a payment weight assigned to it, based on the average resources used to treat Medicare patients in that DRG."[50] For example, Medicare pays a fixed amount for patients discharged for treatment of pneumonia that is different than the amount paid for patients whose

47. *Id.*
48. *Id.*
49. *Id.*
50. CTRS. FOR MEDICARE & MEDICAID SERVS., *Acute Inpatient PPS*, CMS.GOV (last modified Aug. 5, 2019, 1:57 PM), https://www.cms.gov/medicare/medicare-fee-for-service-payment/AcuteInpatientPPS/index.html [https://perma.cc/VD2L-EKYK].

discharge diagnosis is a heart attack or a knee replacement.[51] "This fixed amount is intended to cover the cost of treating a typical patient for a particular DRG."[52] The base payment rate is adjusted based on geographic location, and hospitals treating a "high percentage of low-income patients" receive some "add-on payment[s]" known as the "disproportionate share hospital (DSH) adjustment." [53] Teaching hospitals also receive some additional add-on payments known as the "indirect medical education (IME) adjustment."[54]

Acceptance by the hospitals of Medicare's rates is part of the Conditions of Participation in the Medicare program.[55] CMS unilaterally issues "take it or leave it" updates to its IPPS payment rates each year—basically dictating reasonable pricing levels based upon use of hospital resources, and almost all hospitals "take it," evidently deciding that Medicare's rates are adequate to justify continued participation in the program.[56]

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51. *See* CTRS. FOR MEDICARE & MEDICAID SERVS., *Prospective Payment Systems: General Information*, CMS.GOV, (last modified Mar. 8, 2019, 9:34 AM), https://www.cms.gov/medicare/medicare-fee-for-service-payment/prospmedicarefeesvcpmtgen/index.html [https://perma.cc/H59N-RP42] (explaining that the amount paid for the treatment of a patient with a particular diagnosis is "derived based on the classification system of that service"); Juliette Cubanski et al., *A Primer on Medicare: Key Facts About the Medicare Program and the People It Covers*, HENRY J. KAISER FAMILY FOUND. (Mar. 20, 2015), https://www.kff.org/report-section/a-primer-on-medicare-how-does-medicare-pay-providers-in-traditional-medicare/ [https://perma.cc/5NJL-7F6V] ("DRGs that are likely to incur more intense levels of care and/or longer lengths of stay are assigned higher payments.").

52. CTRS. FOR MEDICARE & MEDICAID SERVS., *Inpatient PPS PC Primer*, CMS.GOV, (last modified Aug. 19, 2019, 4:29 PM), https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/PCPricer/inpatient.html [https://perma.cc/DZ5T-LP8T].

53. CTRS. FOR MEDICARE & MEDICAID SERVS., *supra* note 50.

54. *Id.*

55. *See* CTRS. FOR MEDICARE & MEDICAID SERVS., Transmittal R1808B3, MEDICARE CARRIERS MANUAL PART 3: CLAIMS PROCESS (2003), https://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R1808B3.pdf [https://perma.cc/8AWH-SWSX]; *see also* CTRS. FOR MEDICARE & MEDICAID SERVS., *Hospitals*, CMS.GOV, (last modified Jan. 21, 2015, 4:14 PM), https://www.cms.gov/Regulations-and-Guidance/Legislation/CFCsAndCoPs/Hospitals.html [https://perma.cc/67JT-XGJ6]; CTRS. FOR MEDICARE & MEDICAID SERVS., *Conditions for Coverage & Conditions of Participations*, CMS.GOV, (last modified Nov. 6, 2013, 9:36 AM), https://www.cms.gov/Regulations-and-Guidance/Legislation/CFCsAndCoPs/index.html [https://perma.cc/5DT9-9YL5].

56. Roger Feldman et al., *Medicare's Role in Determining Prices Throughout the Health Care System* 2 (Mercatus Ctr. at George Mason Univ., Working Paper, 2015), https://www.mercatus.org/system/files/Feldman-Medicare-Role-Prices-oct.pdf [https://perma.cc/RAF4-Q3FN] ("Medicare is a take-it-or-leave-it price setter . . . ."); CTRS. FOR MEDICARE & MEDICAID SERVS., *Details for Title: CMS-1677-F; CMS-1677-CN*, CMS.GOV, (Aug. 2, 2017), https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/AcuteInpatientPPS/FY2018-IPPS-Final-Rule-Home-Page-Items/FY2018-IPPS-Final-Rule-Regulations-NEEDS-DISPLAY-DATE.html [https://perma.cc/FD8P-QMWL].

However, the rates set by government insurers like Medicare and Medicaid "are actually below fully allocated cost for most hospitals" according to some research.[57] Therefore, insurance carriers and private payers usually expect to pay more than Medicare rates, but still insurance carriers often base their rates with hospitals upon Medicare's established fee schedules.[58] Commercial insurers pay 1.6 times Medicare rates on average.[59]

Insurance companies generally contract with hospitals with prices stipulated in the contracts. Contract prices paid by insurers are largely secret. Hospitals and medical providers have business interests in keeping the prices actually paid by insurers secret and often include "gag clauses" within the confidential contract terms to prevent disclosure to the public.[60] These business interests include (1) disclosure of bargaining information to competitors, (2) disclosure of higher rates paid to some providers (e.g., hospitals) to relatively lower paid providers (like doctors' offices) for the same service, (3) disclosure of low rates paid by insurers to consumers who are asked to pay much more, (4) disclosure of amount paid for services provided by professionals (like doctors) who are hospital employees, and (5) others.[61]

However, Medicare pricing is not secret and is often the basis upon which insurance contracts are based.[62] For example, an insurer may agree to pay 125% of Medicare for particular procedures or services, rather than placing a fixed price on every service individually.[63]

III. STATE LAW APPROACHES AND POTENTIAL SOLUTIONS FOR PREDATORY HOSPITAL PRICING

State laws generally provide a few, mostly inadequate, avenues to attack surprise hospital overcharges—which will be discussed in this section. First, state contract law approaches will be explored. Second, state hospital price regulation will be discussed. Finally, potential new state law approaches will be examined. Potential state level cures for surprise hospital billing include

57. George A. Nation III, *Determining the Fair and Reasonable Value of Medical Services: The Affordable Care Act, Government Insurers, Private Insurers and Uninsured Patients*, 65 BAYLOR L. REV. 425, 459–60 (2013).

58. Feldman et al., *supra* note 56, at 2 ("Prices set by fee-for-service Medicare have a direct effect on prices paid by private insurers throughout the health care system.").

59. Weissman, *supra* note 10, at 24.

60. *Id.* at 24 n.2 (using the example of Mount Sinai Hospital in Miami Beach).

61. *See id.*

62. Feldman et al., *supra* note 56, at 2.

63. Skinner et al., *supra* note 8 (suggesting capping hospital prices at 125% of Medicare rates).

state court interpretation of contract law in a more patient friendly manner, direct regulation placing limits on hospital pricing, and passage of new laws based on state price gouging/price control laws for other vital products/services.

A. Contract Law

Most patient obligations to pay hospital bills originate in contract law—either express or implied.[64] While many theories have been tried to challenge excessive chargemaster charges,[65] the two state law arguments most likely to gain traction appear to be (1) requiring reasonableness in hospital pricing in claims against patients and (2) invalidating unconscionable pricing terms in hospital "Conditions of Admission" adhesion contracts.

1. Requiring reasonableness in hospital pricing using state contract law

Patients usually are not given a specific price for the hospital's service upon admission to the hospital when signing admitting documents—including any contracts. Therefore, the pricing terms for the patient's hospital stay are often indefinite and implied.

When there is no definite agreement regarding the prices charged in the contract, the charges must be reasonable.[66] Generally, courts have held that the hospital-patient contract reasonably references the hospital's

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64. 41 C.J.S. *Hospitals* § 21 (2019) ("Where there is no express agreement to pay, the law implies a promise to pay a reasonable fee for a health provider's services, [and] . . . . [t]he rights and liabilities of the parties to an express or implied contract are governed by the general law of contract[s].").

65. *See, e.g.*, *id.* ("There is no fiduciary duty that obligates a hospital to charge an uninsured patient the same rates charged to [an] insured."); DiCarlo v. St. Mary Hosp., 530 F.3d 255, 267 (3d Cir. 2008) (finding that health care providers did not breach the duty of good faith and fair dealing); Harrison v. Christus St. Patrick Hosp., 430 F. Supp. 2d 591, 595–96 (W.D. La. 2006) (holding that the contract did not create a fiduciary duty to charge same rate, that the hospital's tax-exempt status does not "confer private rights of action on citizens," and that the hospital did not breach the contract or any duty of good faith); Pagnani-Braga-Kimmel Urologic Assoc., P.A. v. Chappell, 968 A.2d 1242, 1245 (N.J. Super. Ct. Law Div. 2008) ("When looking for mutual assent, a court will take these outward expressions and ask 'what meaning the words should have conveyed to a *reasonable person* cognizant of the relationship between the parties and all of the antecedent and surrounding facts and circumstances.'"); Nygaard v. Sioux Valley Hosps. & Health Sys., 2007 S.D. 34 ¶ 23, 731 N.W.2d 184, 194 (S.D. 2007) (finding that hospitals did not breach the covenant of good faith and fair dealing by charging full undiscounted prices).

66. *Hospitals*, *supra* note 64 ("[I]n the absence of a definite agreement as to what charges are to enter into the contract, the health care provider may decide upon and fix the charges, which must be reasonable.").

chargemaster charges as its usual and customary charges instead of the discounted prices paid by insured patients.[67] According to those courts, chargemaster charges are fixed at a determinable amount prior to rendering the services, which also helps some courts determine that they are "reasonable"[68]; but are they really "determinable" when the patient cannot decipher the chargemaster to determine a price for a particular service? Remember they are often difficult to find and listed in large spreadsheets with medical terminology inaccessible to lay persons. Further, when the patient signs a contract referencing the chargemaster charges, the prices are defined, so some observers determine that they cannot substitute other prices;[69] but, again, are they really "defined" when the patient cannot determine which services will be charged upon admission? Hospitals are generally not found to be unjustly enriched by high chargemaster charges.[70]

However, the tide may be turning in this area in some state courts. A contract is implied by law under "quasi-contract" theory when there is no express contract between the parties and one party has received unjust enrichment at the expense of another.[71] Hospitals use this argument to collect payment from patients when there is no express contract regarding prices for payment for services.[72] The typical elements of unjust enrichment claims are (1) "benefits conferred on defendant by plaintiff," (2) "appreciation of such benefits by defendant," and (3) "acceptance and retention of such benefits [such that] it would be inequitable for defendant to retain the benefit without payment of value" (i.e., "whether the

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67. *See, e.g.*, Holland v. Trinity Health Care Corp., 791 N.W.2d 724, 730 (Mich. Ct. App. 2010) (holding that the term 'usual and customary charges' in financial agreement between patient and hospital reasonably referenced hospital's "charge master prices rather than the discounted prices charged to insured patients); *Nygaard*, 2007 S.D. 34, ¶¶ 15–17, 731 N.W.2d at 191–93 (dismissing patient-plaintiffs' claim that their agreements with hospitals contained an implied term that hospitals would charge no more than the fair and reasonable charges for medical care).

68. *Hospitals*, *supra* note 64 ("[T]he prices are thus fixed at a given amount prior to the execution of the agreements; and thus, the prices charged by the hospitals are determinable.").

69. *Id.* (observing that when "a contract . . . refers to the hospital's chargemaster rates . . . the contract is not indefinite as to price, and therefore, a reasonable price term could not be imputed into the contract").

70. *See, e.g.*, *Harrison*, 430 F. Supp. 2d at 596–97 (finding that the hospital was not unjustly enriched); Cox v. Athens Reg'l Med. Ctr., Inc., 631 S.E.2d 792, 798 (Ga. Ct. App. 2006) (dismissing patients claim against hospital for unjust enrichment); Firelands Reg'l Med. Ctr. v. Jeavons, 2008-Ohio-5031, No. E-07-068, 2008 WL 4408600, at *5 (Ohio Ct. App. Sept. 30, 2008) (finding that any benefit conferred upon health care provider by maintaining accounts receivable on unpaid bills was "too speculative . . . to sustain an unjust enrichment claim").

71. Temple Univ. Hosp., Inc. v. Healthcare Mgmt. Alts., Inc., 832 A.2d 501, 507 (Pa. Super. Ct. 2003) ("When there is no express contract between the parties, a plaintiff may still recover under a quasi-contract theory. In this situation, a contract is implied by the law.").

72. *See, e.g.*, *id.*

enrichment of the defendant is unjust").[73] "Unjust enrichment arises where one party fulfills the duty of another and the benefited party does not compensate the burdened party."[74]If unjust enrichment is found, "the law implies a quasi-contract which requires the defendant to pay to plaintiff the value of the benefit conferred" by making "restitution to the plaintiff in *quantum meruit*."[75] Quantum meruit means "as much as he deserves."[76] So the question becomes: Exactly how much does the hospital deserve?

Fair market value, often equated with "reasonable" price, is generally considered to be the price that "a willing buyer would pay to a willing seller, neither being under compulsion to buy or sell, and both having full knowledge of all pertinent facts."[77] To determine fair market value or "reasonable" value in *quantum meruit* cases, courts generally accept a "wide variety of evidence."[78] Some courts find that the prices paid by insurers and government are better measures of "reasonable" charges or fair market value than chargemaster charges. For example, a Pennsylvania court held that the hospital was entitled only to its "average charges" paid by insurers and government payers, not the chargemaster charges.[79] The court noted:

> Reasonable value . . . is the value paid by the relevant community. The relevant community in this case comprises the Hospital's patients who are covered by insurance policies and federal programs. Thus, *the Hospital should be awarded the average charge for the services at issue contained in contracts with governmental agencies and insurance companies.*[80]

The court also recognized that the hospital was seeking to be "awarded a windfall" above the "reasonable value of its services" by seeking chargemaster charges.[81] Similarly, in another *quantum meruit* case, a California court noted that in determining the fair market value of the

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73. *Id.* at 515 (Tamilia, J., dissenting) (quoting AmeriPro Search, Inc. v. Fleming Steel Co., 787 A.2d 988, 991 (Pa. Super. Ct. 2001)).

74. Pagnani-Braga-Kimmel Urologic Assoc., P.A. v. Chappell, 968 A.2d 1242, 1244 (N.J. Super. Ct. Law Div. 2008) (citing St. Barnabas Med. Ctr. v. Essex Cty., 543 A.2d 34, 40–41 (N.J. 1988)).

75. *Temple*, 832 A.2d at 507 (quoting *AmeriPro Search, Inc.*,, 787 A.2d at 991).

76. Candace S. Kovacic, *A Proposal to Simplify Quantum Meruit Litigation*, 35 AM. U. L. REV. 547, 550 (1986) (citing *Quantum Meruit*, BLACK'S LAW DICTIONARY (5th ed. 1979)).

77. Children's Hosp. Cent. Cal. v. Blue Cross of Cal., 172 Cal. Rptr. 3d 861, 872 (Ct. App. 2014) (quoting Alameda Cty. Flood Control & Water Conservation Dist. v. Dep't of Water Res., 152 Cal. Rptr. 3d 845, 854 n.9 (Ct. App. 2013)).

78. *Children's Hosp. Cent. Cal.*, 172 Cal. Rptr. 3d at 872.

79. *Temple*, 832 A.2d at 509.

80. *Id.* at 510 (emphasis added).

81. *Id.* at 509.

hospital's services, "[t]he scope of the rates accepted by or paid to the Hospital by other payors indicates the value of the services in the marketplace."[82]

Hospitals often use state lien laws to attempt to exploit patients and extract inflated chargemaster prices. However, some state courts are beginning to help stop this overcharging tactic. In many states, the validity of a hospital lien rests upon whether the hospital's charges are reasonable and customary. In 2018, the Texas Supreme Court observed

> the issue is not whether [the patient] may take advantage of insurance she did not have. Rather, because a valid hospital lien may not secure charges that exceed a reasonable and regular rate, the *central issue in a case challenging such a lien is what a reasonable and regular rate would be*.[83]

The Texas Supreme Court concluded, "because of the way chargemaster pricing has evolved, the *charges themselves are not dispositive of what is reasonable*, irrespective of whether the patient being charged has insurance."[84] Instead, the court went on to find that since "a hospital's reimbursements from private insurers and public payers comprise the vast majority of its payments for services rendered," those reimbursements were relevant in determining what is a reasonable and customary charge to enforce a lien against other patients who received the same services.[85]

Courts in other states have agreed with the Texas Supreme Court. For example, the Georgia Supreme Court found that "documents regarding the amounts the hospital charged insured patients for the same type of care" during the same time period were discoverable (and hence relevant).[86] Similarly, an Indiana court held that the patient was entitled to discover information about discounted amounts the hospital accepted from patients who had private insurance or were covered by government programs.[87] In another example, a United States District Court in Florida concluded that the plaintiff's assertions that the hospital's charges were unreasonable would be supported by evidence that "patients with [private] insurance and government

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82. *Children's Hosp. Cent. Cal.*, 172 Cal. Rptr. 3d at 873 ("Analogizing this situation to other quantum meruit cases, relevant evidence would include the full range of fees that Hospital both charges and accepts as payment for similar services. The scope of the rates accepted by or paid to Hospital by other payors indicates the value of the services in the marketplace.").

83. *In re N. Cypress Med. Ctr. Operating Co.*, 559 S.W.3d 128, 133 (Tex. 2018) (emphasis added).

84. *Id.* (emphasis added).

85. *Id.*

86. *Bowden v. Medical Ctr., Inc.*, 773 S.E.2d 692, 693 (Ga. 2015).

87. Parkview Hosp., Inc. v. Frost *ex rel.* Riggs, 52 N.E.3d 804, 805–06, 810 (Ind. Ct. App. 2016).

benefits received significant discounts . . . for the hospital's services" suggesting that the "value of the services charged to [the] Plaintiff may be significantly less" than she was asked to pay.[88]

In some states, hospitals may have additional duties to patients that can impact *quantum meruit claims*. State level governmental obligations to "provide health care services . . . may be found in a number of state constitutions"—with "[t]hirteen state constitutions contain[ing] provisions which specifically refer to health."[89] For example in New Jersey, hospitals have a duty under state law "to accept and treat all patients," so the patient may argue that the hospital would be unjustly enriched by receiving higher out-of-network charges based upon chargemaster prices and is "better suited to absorb the cost" than the patient.[90]

2. Invalidating unconscionable "Conditions of Admission" adhesion contracts

Some state courts may find that documents that patients are asked to sign upon hospital admission—especially in emergency or urgent situations—are unenforceable because they are unconscionable adhesion contracts. When the contract sets pricing using excessive chargemaster overcharges, a strong argument can be made that the adhesion contract should not be enforced.

An "adhesion contract" is a standardized form contract offered to patients "on essentially a 'take it or leave it basis' without affording the [patient] a realistic opportunity to bargain and under such conditions that the [patient] cannot obtain the desired . . . service[s] except by acquiescing" by signing the form contract.[91] Adhesion contracts generally are considered to refer to those in which "the weaker party has no realistic choice as to its terms."[92]

At least one court has found that "[a] hospital's standard printed 'Conditions of Admission' form possesses all the characteristics of a contract of adhesion,"[93] noting:

> The would-be patient is in no position to reject the proffered agreement, to bargain with the hospital, or in lieu of agreement to

88. Colomar v. Mercy Hosp., Inc., 461 F. Supp. 2d 1265, 1266, 1271–72 (S.D. Fla. 2006).

89. KATHLEEN S. SWENDIMAN, CONG. RESEARCH SERV., R40846 HEALTH CARE: CONSTITUTIONAL RIGHTS & LEGISLATIVE POWERS 16 (2012), https://fas.org/sgp/crs/misc/R40846.pdf [https://perma.cc/95H5-QEKV].

90. Pagnani-Braga-Kimmel Urologic Assoc., P.A. v. Chappell, 968 A.2d 1242, 1244 (N.J. Super. Ct. Law Div. 2008).

91. Wheeler v. St. Joseph Hosp., 133 Cal. Rptr. 775, 783 (Ct. App. 1976).

92. *Id.*

93. *Id.*

> find another hospital. The admission room of a hospital contains no bargaining table where, as in a private business transaction, the parties can debate the terms of their contract. As a result, we cannot but conclude that the instant agreement manifested the characteristics of the so-called adhesion contract.[94]

However, determining that the contract is an adhesion contract is only the beginning of the analysis of enforceability.[95]

Enforceability of adhesion contracts depends "upon whether the terms of which the adherent was unaware are beyond the *reasonable expectations of an ordinary person* or are oppressive or *unconscionable*."[96] For standardized contracts, courts must "determine what the weaker contracting party could legitimately expect by way of services . . . and to what extent the stronger party disappointed reasonable expectations based on the typical life situation."[97] No "typical life situation" comes to mind—not even on used car lots—where the seller of a product or service routinely charges unsuspecting people *triple* the amount that it typically accepts as payment in full for the same product or service and may often charge *ten times* the amount routinely accepted as payment in full.[98] Therefore, an ordinary person would likely expect the hospital to charge patients a "reasonable" amount in line with its routine level of reimbursement—which is more in line with the experience of the dealings of ordinary people with respected businesses.

"To the ordinary person, admission to a hospital is an anxious, stressful, and frequently a traumatic experience" such that the hospital can "hardly expect the patient to read the printed conditions on an admission form, much less understand the meaning" of complex terms like "chargemaster" charges.[99] An ordinary person could reasonably expect "Conditions of Admission" contracts to include an obligation to pay for the services rendered by the hospital *at prices consistent with the prices it generally accepts for similar services*—not exorbitant chargemaster charges that the hospital receives less than 5% of the time.

"Courts may refuse to enforce a term within a party's reasonable expectations if that term is unconscionable," which may apply to excessive chargemaster overcharges as noted above.[100] A procedurally unconscionable contract is one that is "entered into hastily and/or in an emergency situation,

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94. *Id.* (quoting Tunkl v. Regents of the Univ. of Cal., 383 P.2d 441, 447 (Cal. 1963)).
95. *Id.*
96. *Id.* (emphasis added).
97. *Id.*
98. *See* Nation, *supra* note 19, at 680–81.
99. *Wheeler*, 133 Cal. Rptr. at 786.
100. Banner Health v. Med. Sav. Ins. Co., 163 P.3d 1096, 1109 (Ariz. Ct. App. 2007) (Kessler, J., concurring in part and dissenting in part).

when its terms are not explained at the time it is signed, and when the document does not call attention to terms to be enforced against the signing party."[101] Standardized form contracts referencing excessive chargemaster charges signed during emergency or urgent situations may be procedurally unconscionable.

In addition, contracts may be substantively unconscionable when there is "gross disparity in the values exchanged, unduly oppressive terms, and [an] overall imbalance in the rights and protections of the parties."[102] Hospital contracts that reference chargemaster charges routinely triple and often many more times the amounts typically paid by 95% of payers clearly "include gross disparity in the values exchanged" and are "unduly oppressive."[103] The fact that medical bills contribute to over half of bankruptcies and result in significant financial issues for large numbers of Americans supports the oppressiveness of the chargemaster system.[104]

However, courts generally hold that hospital contracts referencing chargemaster charges are not unconscionable[105]—but the case law tends to be very state specific; so, in some states, courts may be primed to find that Conditions of Admission contracts referencing exorbitant chargemaster charges are unenforceable adhesion contracts.

B. Consumer Protection Laws

Consumer protections in most states against predatory hospital chargemaster charges are mostly minimal. New state law limits should be placed on hospital chargemaster charges.

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101. *Id.*

102. *Id.* (citing RESTATEMENT (SECOND) OF CONTRACTS § 208 (1981)).

103. *Id.*

104. Jacoby et al., *supra* note 16, at 377 ("Nearly half of *all* bankruptcies involved a medical problem.").

105. *See, e.g.*, DiCarlo v. St. Mary Hosp., 530 F.3d 255, 267–68 (3d Cir. 2008) (noting that professionals were not covered by the New Jersey Consumer Fraud Act's unconscionability standards); Geico Indem. Ins. Co. v. Kannaday, No. 06-1067-JTM, 2007 WL 2990552, at *2 (D. Kan. Oct. 11, 2007) (quoting State *ex rel.* Stovall v. ConfiMed.com, L.L.C., 38 P.3d 707, 708 (Kan. 2002) ("Where a record is devoid of any evidence of deceptive or oppressive practices, overreaching, intentional misstatements, or concealment of facts, there are no grounds for a claim of unconscionability under the Kansas Consumer Protection Act.")).

1. Current and previously tried state approaches

Consumer protection laws addressing exploitation of patients by excessive chargemaster charges are largely lacking. However, some states have at least a few protections for patients who are uninsured or out-of-network.

For the uninsured, occasional state law protections include: (1) fair pricing laws, (2) limits on medical debt collection practices, and (3) potential avenues for complaints and complaint resolution. First, at least thirteen states have state fair pricing laws that limit how much hospitals can charge uninsured patients who earn below certain income levels.[106] For example, California passed its Fair Pricing Act in 2006, which limits the amount that hospitals may charge patients who earn less than 350% of the federal poverty level (FPL) and insured patients whose medical bills exceed 10% of their income.[107] In those cases, California hospitals cannot charge patients more than the highest amount paid by a government payer like Medicare or Medicaid.[108] Most California hospitals went beyond the requirements of the Act, with 97% offering free care to patients earning below the FPL and many limiting charges to Medicare rates for patients above 350% of FPL.[109]

Similarly, New Jersey has a 2008 law that limits hospital charges to uninsured patients making up to 500% of the FPL to 115% of Medicare rates; the New Jersey law also requires hospitals to provide free care to patients making less than 200% of FPL.[110] Nevada takes a different approach by requiring hospitals to "discount the total billed charge by at least 30[%]" for uninsured and out-of-network patients who are not eligible for Medicare or Medicaid.[111] Of course, if the bill originally charges ten times the amount typically paid, the patient still must pay 70% of the bill—which can still be seven or more times the amount typically paid, if the patient is at a particularly aggressive hospital.

Second, some states regulate hospital debt collection practices by limiting interest rates, foreclosures, liens, wage garnishment, etc.[112] While these laws do not prohibit the exorbitant charges, they may limit hospitals' ability to collect the overcharges and encourage settlement for rates more in line with average amounts typically collected. Further, while not a state law issue, overly aggressive nonprofit hospitals may run afoul of 26 U.S.C. § 501(r)(6)

106. Erin C. Fuse Brown, *Resurrecting Health Care Rate Regulation*, 67 HASTINGS L.J. 85, 125 (2015).
107. *Id.* at 126.
108. *Id.*
109. *Id.*
110. *Id.*
111. *See* NEV. REV. STAT. § 439B.260 (2017).
112. Brown, *supra* note 106, at 125.

by "engag[ing] in *extraordinary collection actions* [ECAs] before the organization has made reasonable efforts to determine whether the individual is eligible for assistance under the financial assistance policy."[113] ECAs include actions like placing liens on or foreclosing on patients' homes, filing lawsuits against patients, seizing bank accounts, garnishing wages, arrests, etc.[114] Therefore, depending upon the patient's circumstances, a hospital's nonprofit status can be challenged and potentially revoked for violation of 501(r),[115] which may motivate hospitals to deal more fairly with debtor patients and make chargemaster charges fall more in line with amounts generally paid by insurers and government payers. The federal law is discussed further in the appropriate section below.

Third, some states provide opportunity for complaints regarding unfair billing and potential avenues for resolution. For example, in Texas, complaints against hospitals are filed with the Texas Department of State Health Services.[116] Consumers should check with similar state entities to see what type of complaint resolution processes are in place in their home state and at least file complaints when possible to flag the issue of predatory hospitals who are overcharging patients.

For patients who are out-of-network, a few states have some minor protections. Roughly twenty-one states have some type of consumer protections for out-of-network billing for care in emergency rooms and in-network hospitals, but all have major gaps according to a 2017 Commonwealth Fund study.[117] Twelve states restrict balance billing by out-of-network providers.[118] Balance billing protections against out-of-network providers are provided by at least twelve states for HMO members and by at least eight states for PPO members, with some protections extending only to emergency care and others extending to all medical care

113. 26 U.S.C. § 501(r)(6) (2018) (emphasis added).

114. Treas. Reg. § 1.501(r)-6 (2019).

115. Treas. Reg. § 1.501(r)-2 (2019).

116. TEX. HEALTH & HUMAN SERVS., TEX. DEP'T OF STATE HEALTH SERVS., *How to File a Complaint—Health Facilities*, https://hhs.texas.gov/about-hhs/your-rights/complaint-incident-intake/how-do-i-make-a-complaint-about-hhs-service-provider [https://perma.cc/G4ME-YDZ9] (describing the process to file a complaint); *see also* Tex. Dep't of Ins., *Surprise Medical Bills*, https://www.tdi.texas.gov/consumer/cpmbalancebilling.html [https://perma.cc/F6LR-JF4U] (describing what a patient can do if he or she receives a "surprise" medical bill).

117. Bryant, *supra* note 35 ("Of the 21 states offering protections as of [2017], just six had a 'comprehensive approach to protecting consumers' . . . and even those had gaps, according to a June 2017 Commonwealth Fund study.").

118. Brown, *supra* note 106, at 126–27.

covered by the member's plan.[119] However, "state balance billing laws may be preempted by ERISA for self-insured employer plans."[120]

In addition, around fifteen state regulators provide a complaint resolution process for surprise medical bills for patients who incur unavoidable out-of-network charges.[121] Three states (California, Florida, and New York) have even extended these protections to include all hospital stays—not just emergency department (ED) visits.[122] The process for complaint resolution varies by state with different offices involved and with procedures even being in place in some states without specific out-of-network protections.[123]

In addition to the more focused approaches above, some states have protections for both uninsured and out-of-network patients—although the protections are generally minimal. New York has some of the strongest protections with the Emergency Medical Services and Surprise Bills law having four major provisions: (1) holding patients harmless for emergency medical services and surprise inpatient hospital bills while imposing significant disclosure requirements on hospitals and doctors, (2) providing for binding arbitration dispute resolution, (3) extending New York's network adequacy rules to apply to all regulated health insurance products, and (4) providing special rules for dispute resolution for patients who are uninsured.[124]

Over the years, states have tried unsuccessfully to address this issue with some rate-setting provisions. In the 1960s and 70s, "at least 27 states implemented programs . . . to either review or directly regulate hospital rates and budgets."[125] These were mostly "voluntary approaches involving public

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119. Adam Crowther, *Out of Control: Patients Are Unwittingly Subjected to Enormous, Unfair, Out-of-Network 'Balance Bills*,*'* PUB. CITIZEN (Apr. 16, 2014), https://www.citizen.org/wp-content/uploads/out-of-network-balance-billing-report.pdf [https://perma.cc/LQ4Q-3KYE].

120. Brown, *supra* note 106, at 127.

121. Walecia Konrad, *Surprise Medical Bills: How You Can Fight Back*, CBS NEWS: MONEYWATCH (November 23, 2016, 5:15 AM), https://www.cbsnews.com/news/surprise-medical-bills-how-you-can-fight-back/ [https://perma.cc/79CY-VLX9]; *see, e.g.*, Dena Mendelsohn, *Insurance Complaint Tool*, CONSUMER REP. (Mar. 1, 2018) https://advocacy.consumerreports.org/research/insurance-complaint-tool/ [https://perma.cc/8B6F-2U9Y].

122. Konrad, *supra* note 121.

123. *Id.*

124. Bryant, *supra* note 35 ("[F]or consumers with unregulated products, such as a self-insured plan, if a balance exists after their plan has paid, the balance is treated as if they were uninsured and put into dispute resolutions, potentially letting the consumer off the hook.").

125. Robert Murray & Robert Berenson, *Hospital Rate Setting Revisited: Dumb Price Fixing or a Smart Solution to Provider Pricing Power and Delivery Reform?*, URBAN INST.,

disclosure and/or the nominal review of hospital rates . . . by a state agency," although some states had more significant mandatory rate setting provisions.[126]

State hospital rate setting laws have largely been repealed in the name of deregulation. At one time, New Jersey had a Hospital Rate Setting Commission that considered the "costs involved in providing health care and established a scheme of rate regulation for New Jersey hospitals."[127] This scheme was "crafted to protect hospitals . . . by setting the rates for medical services high enough to compensate for those cases in which the hospital is never paid."[128] In 1992, Republican majorities in the New Jersey legislature helped end its rate setting system.[129] During the same time frame, most other states similarly dropped rate setting as hospitals were deregulated.[130]

In contrast to other states, Maryland has maintained a stable "all-payer hospital rate setting program."[131] The program has been credited with reducing Maryland's cost per admission.[132] An independent state agency, the Health Services Cost Review Commission (HSCRC), began setting Maryland hospital rates in 1974.[133] One of the stated policy goals of the HSCRC statute was to "increase the equity and fairness of the payment system."[134] Maryland is an exception:

> In sum, four factors have enabled Maryland to keep rate setting on track: (1) the ability to prevent HMOs from engaging in competitive discounting; (2) the statutory flexibility provided to system

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https://www.urban.org/sites/default/files/publication/73841/2000516-Hospital-Rate-Setting-Revisited.pdf [https://perma.cc/4VJG-HKBD].

126. *Id.*

127. Pagnani-Braga-Kimmel Urologic Assoc., P.A. v. Chappell, 968 A.2d 1242, 1244 (N.J. Super. Ct. Law Div. 2008).

128. *Id.* at 1245.

129. John E. McDonough, *Tracking the Demise of State Hospital Rate Setting*, 16 HEALTH AFF., Jan.–Feb. 1997, at 142, 146, https://www.healthaffairs.org/doi/full/10.1377/hlthaff.16.1.142 [https://perma.cc/QX7F-E33Y] ("In 1992 newly elected Republican majorities in the New Jersey Assembly and Senate bargained with Democratic Governor James Florio to end that state's pioneering DRG system.").

130. *Id.* at 143 (listing Wisconsin, Massachusetts, Maine, and New York as examples); Murray & Berenson, *supra* note 125, at x ("Following the election of Republican governors in Massachusetts and New York in the early 1990s, hospital rate setting was abandoned in Massachusetts in 1991 and in New York in 1997. The other rate setting states, except for Maryland and West Virginia, joined the exodus.").

131. Murray & Berenson, *supra* note 125, at xii.

132. *Id.* ("The enabling legislation was enacted in 1971, at which time Maryland hospitals' cost per admission was more than 25[%] above the US average."); *id.* at xiv ("By 1993, Maryland cost per admission was more than 11[%] below the US average.").

133. *Id.*

134. *Id.*

> managers to adapt to new circumstances; (3) the maintenance of the Medicare waiver that places regulatory opponents on the financial defensive; and (4) the maintenance of Democratic control in the executive and legislative branches. Until some or all of these change, the Maryland system is likely to continue.[135]

West Virginia likewise has had some success with rate setting system administered by the West Virginia Health Care Authority (HCA).[136] The HCA helps protect the public from "unreasonable or unnecessary increases in the cost of acute care hospital services."[137] West Virginia's rate setting system has gotten "reasonable support from the hospital industry" (1) because it "permits relatively generous growth in charges" and (2) because it "has adopted a gentle regulatory approach by establishing relatively wide corridors for approved charge increases . . . and other terms in the contracting between hospitals and payers."[138]

2. Author's proposed state law approaches

States should adopt laws that (1) limit hospital chargemaster rates to some multiple of a "reasonable" charge based upon prices actually paid to hospitals for their services, and (2) adopt price gouging laws that apply to hospitals billing vulnerable patients facing medical emergencies.

a. Limiting hospital chargemaster rates by state statute

Instead of rate setting, states should take a *rate limiting approach* to hospital chargemaster charges; i.e., hospitals should not be allowed to charge patients more than some limit above "reasonable" rates based on real prices paid by payers like Medicare and insurance companies.

There are multiple ways "reasonable" hospital chargemaster rate limits can be determined by states. First, states can enact legislation that limits hospital pricing to some multiple of the amount paid by government payers like Medicare or Medicaid. Medicare rates are set by CMS and are available and updated regularly by CMS, which makes them excellent for establishing current reasonable charges.[139] For example, as mentioned above, California's Fair Pricing Act limits the amount that hospitals can charge uninsured,

135. McDonough, *supra* note 129, at 146.

136. Murray & Berenson, *supra* note 125, at xi.

137. *Id.*

138. *Id.* at xii.

139. Nation, *supra* note 19, at 683, 685 (noting that (1) "Medicare rates are . . . set by [CMS]," (2) "can be used to establish the usual, customary, and reasonable price," and (3) "are readily available and updated regularly by CMS").

low-income patients to the highest amount paid by government payers like Medicare or Medicaid.[140] Similarly, New Jersey's law limits charges to low-income, uninsured patients to 115% of Medicare rates.[141] Likewise, Maryland limits the amount paid at trauma centers to 140% of the rate Medicare would pay to a similar provider in similar circumstances (geographic area, procedure, etc.).[142]

Currently, hospitals charge a median of around 4.2 times Medicare rates in their emergency departments, with some hospitals charging up to over 27.7 times the Medicare allowable amount for some services.[143] States could take a non-drastic approach and simply limit hospital chargemaster charges to no more than 400% of Medicare rates and save patients from being exploited and victimized by predatory hospitals charging over ten to twenty-five times the Medicare rate.

Second, states could limit chargemaster charges to some multiple of the average rates collected from all payers so that patients are not being charged prices dramatically different from those being paid by the majority of payers. Average hospital chargemaster charges are currently over triple the "actual payments for [hospital] services," and are often more than ten times the Medicare allowable.[144] New federal regulations (discussed in detail below Section IV) related to nonprofit hospitals may also serve as guidance in determining fair price limits at the state level where they prohibit some patients (i.e., those eligible for financial assistance under the nonprofit's financial assistance policy) from being charged more than the "amounts generally billed" (AGB) and prohibit hospitals from charging those specific patients full chargemaster rates.[145] Those regulations provide methods for determining AGB that could be used by states as a starting point to apply to hospital billing of all patients, so that everyone is billed a similar amount—or at least an amount in the same ballpark—for the same service.

Third, states could limit hospital chargemaster rates to some multiple of hospitals' average negotiated rate with private insurers; for example, the state could limit chargemaster rates to "average negotiated private insurance rate

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140. Brown, *supra* note 106, at 126.

141. *Id.*

142. Crowther, *supra* note 119.

143. Xu et al., *supra* note 1, at 1142.

144. Michael Batty & Benedic Ippolito, *Mystery of the Chargemaster: Examining the Role of Hospital List Prices in What Patients Actually Pay*, 36 HEALTH AFF. 689, 689 (2017) (noting that actual payments differ from charges "by more than a factor of three"); Nation, *supra* note 19, at 680–81 (noting "that on average chargemaster prices are more than 300[%] of the amount hospitals actually get paid for their goods and services" and can often be "in excess of 10 times the Medicare allowable cost.").

145. 26 C.F.R. § 1.501(r)–1(16).

plus ten to fifteen percent."[146] The "only effective free market that exists with respect to healthcare is the market between hospitals and private insurance companies."[147] Hospital and insurance company contracts are freely entered into, negotiated robustly, and are frequently analyzed and renegotiated—usually annually—with both parties operating with "significant knowledge and market power."[148] Private insurance companies "provide benefits to hospitals" that self-pay and out-of-network patients do not—like volume promises of "many new patients" and "quick and assured payment."[149] But these benefits "come nowhere close to accounting for the huge difference [often triple markup] between negotiated contract-based rates and grossly inflated chargemaster rates" and likely "represent no more than ten to fifteen percent of negotiated rates."[150]

In cases of emergencies, the argued benefits provided by private in-network contracts are minimal since EMS providers generally take patients to the closest facility in an emergency situation regardless of any pre-negotiated insurance arrangements.[151] Using this third proposed model, hospitals can set their rates as they wish, as long as they can get market participants in similar negotiating positions (like insurance companies) to comply; and other patients can benefit from the market forces at play and pay prices within 10 to 15% percent of less vulnerable market participants for the same services—instead of being asked to pay over 10 to 25 times the market determined value.

b. Passing "price gouging" laws to protect vulnerable people during personal emergencies

States should pass price gouging laws to protect vulnerable people from exploitation by excessive hospital chargemaster prices during personal medical emergencies and crises. Price gouging is defined as "the charging of 'grossly excessive' . . . prices" and is prohibited in many states "during 'states of emergency' (as after a flood or other natural disaster)."[152] Hospital charges averaging triple the average reimbursement,[153] averaging over

146. Nation, *supra* note 19, at 683.
147. *Id.*
148. *Id.* at 683–84.
149. *Id.* at 684.
150. *Id.* at 684–85.
151. Nation, *supra* note 19, at 685.
152. Christine Jolls et al., *A Behavioral Approach to Law and Economics*, 50 STAN. L. REV. 1471, 1510 (1998).
153. Nation, *supra* note 19, at 680–81 (explaining that on average, "chargemaster prices are more than 300[%] of the amount hospitals actually get paid for their goods and services" and can often be "in excess of 10 times the Medicare allowable cost.").

quadruple the Medicare allowable,[154] and often 10 to 27.7 times the Medicare allowable[155] could likely meet the definition of "price gouging" applied to other industries.

Price gouging in other industries has led to considerable political and public outrage. For instance, "[w]hen gas prices soared in the wake of Hurricane Katrina[] . . . President Bush . . . equated gasoline price-gougers with looters" during a television appearance.[156] When gas prices reached almost $6.00 per gallon after Hurricane Katrina, "[p]ublic outrage soared" with 72% of respondents in one poll believing oil companies were guilty of gouging and with 80% finding fault in "the federal government's response to the oil companies' tactics"—evidenced by "5,000 angry consumers contact[ing] the Energy Department's hotline to complain of gas price gouging."[157] A similar situation arose in the aftermath of the September 11 attacks on New York and Washington when around fifty Michigan gas station owners immediately doubled gas prices.[158] The Michigan Attorney General "immediately listed fifty offending [gas] stations, demanded apologies and refunds for customers, and ordered the payment of fines for violations of the [Michigan's] Consumer Protection law," and almost all of the gas stations complied.[159]

A recent trend has occurred with the "widespread adoption of state consumer protection laws designed to prevent price gouging after natural or man-made disasters."[160] Many states have consumer protection laws that prohibit price gouging for vital services like gasoline prices, truth in lending, and motor vehicle repairs—yet, amazingly, similar laws are lacking to protect consumers from predatory hospitals.[161] Similar consumer protection laws are necessary to protect patients during personal "disasters" related to serious medical conditions.

Although thirty-four states and D.C. have price gouging laws, none apply directly to excessive chargemaster charges by hospitals because they

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154. *See also* Xu et al., *supra* note 1, at 1139, 1142 (reporting that nationwide, hospitals charge an average of 4.2 times the amount typically collected, and some hospitals charged up to 12.6 times the amount typically collected for emergency department services; in other words, an emergency patient might get a bill for $12,600 for a service typically paid at $1,000 at some hospitals).

155. *Id.* at 1142 (reporting a markup ratio of 7.0 for laceration repairs and a markup ratio up to 27.7 for reading of a head CT by the emergency room doctor at one hospital).

156. Geoffrey C. Rapp, *Gouging: Terrorist Attacks, Hurricanes, and the Legal and Economic Aspects of Post-Disaster Price Regulation*, 94 KY. L.J. 535, 536 (2006).

157. *Id.* at 537.

158. *Id.*

159. *Id.*

160. *Id.* at 537–38.

161. Weissman, *supra* note 10, at 22.

generally require an officially declared state of emergency (e.g., by the governor of the state), apply to physical commodities like gasoline (not services), and do not include a private right of action for individuals affected. [162] For example, in Florida there is a prohibition against unconscionable prices during a declared state of emergency.[163] In Arkansas, businesses are prohibited from charging more than 10% above the pre-disaster price of goods or services during a state of emergency.[164] In Georgia, if a state of emergency is declared, it is unlawful:

> to sell or offer for sale at retail any goods or services identified by the Governor in the declaration of the state of emergency *necessary to preserve, protect, or sustain the life, health, or safety of persons or their property* at a price higher than the price at which such goods were sold or offered for sale immediately prior to the declaration of a state of emergency.[165]

Thus, numerous states recognize the need to protect individuals during emergency situations.

Price-gouging laws are generally passed to protect vulnerable populations.[166] In natural disasters, individuals are vulnerable to injury and loss of life or limb and need urgent access to critical supplies and services. During an emergency, people may have little choice other than to pay whatever price is demanded for critical services or goods because they are

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162. Michael Giberson, *List of State Anti-Price Gouging Laws*, KNOWLEDGE PROBLEM (Nov. 3, 2012), http://knowledgeproblem.com/2012/11/03/list-of-price-gouging-laws [https://perma.cc/UB8F-UG6T].

163. FLA. STAT. ANN. § 501.160 (West 2019).

164. ARK. CODE ANN. § 4-88-303 (West 2019) ("Upon the proclamation of a state of emergency resulting from a tornado, earthquake, flood, fire, riot, storm, or natural or man-made disaster declared by the President of the United States or the Governor and upon the declaration of a local emergency resulting from a tornado, earthquake, flood, fire, riot, storm, or natural or man-made disaster by the executive officer of any city or county and for a period of thirty (30) days following that declaration or during any period of time during which a red condition under the Homeland Security Advisory System has been declared by either the United States Department of Homeland Security or the Arkansas Department of Emergency Management, it is unlawful for any person, contractor, business, or other entity to sell or offer to sell any consumer food items or goods, goods or services used for emergency cleanup, emergency supplies, medical supplies, home heating oil, building materials, housing, transportation, freight, and storage services, or gasoline or other motor fuels for a price of *more than ten percent (10%) above the price charged by that person for those goods or services immediately prior to the proclamation of emergency*." (emphasis added)).

165. GA. CODE ANN. § 10-1-393.4 (2019) (emphasis added).

166. Caitlin E. Ball, *Sticker Shock at the Pump: An Evaluation of the Massachusetts Petroleum Price-Gouging Regulation*, 44 SUFFOLK U. L. REV. 907, 908, 911 (2011) (noting that "many argue that gouging is a form of 'profiteering' at the expense of vulnerable consumers" and that price gouging is "frequently associated with greed on the part of sellers in tandem with consumer vulnerability").

vulnerable to loss of life, limb or other life-altering consequences if they refuse. The situation is basically analogous to making a decision with a gun to your head.

When an individual enters the emergency room, he or she often faces an imminent threat of severe injury or loss of life or limb—just like consumers during natural disasters—which makes emergency patients extremely vulnerable and equally worthy of special protections. If a Michigan gas station charging desperate consumers *double* normal gas prices is price gouging, why shouldn't a hospital charging *triple* normal prices to desperate patients likewise be guilty? Just as states prohibit gas stations from hiking gasoline prices as residents attempt to flee from the hurricane path, state governments should prevent hospitals from setting emergency service prices artificially high to trap vulnerable patients during personal emergencies. States should do more to protect vulnerable patients—and price gouging laws are a good model upon which to base new laws prohibiting exorbitant surprise hospital billing for emergency or urgent services/supplies.

IV. FEDERAL APPROACHES TO PREDATORY HOSPITAL PRICING

Under current federal law, financially exploited patients have limited options to fight back against abusive hospitals—but a few possible protections under current laws are examined here. In addition, current and potential policy proposals to help address the problem are explored in this section.

A. Using Current Law to Help Victims of Surprise Hospital Billing

Victims of abusive hospital billing practices have limited federal protections to address unfair hospital bills. Legal strategies may include (1) challenging hospitals' nonprofit status when they exploit patients with excessive chargemaster prices, (2) disparate impact discrimination litigation when protected populations are routinely charged more than others, and (3) antitrust actions against monopoly hospitals with exorbitant chargemaster prices.

1. Challenging hospitals' tax-exempt status

One strategy to fight exorbitant hospital chargemaster charges is to challenge nonprofit hospitals' 501(c)(3) status[167] using 26 U.S.C. 501(r)[168] (a provision included in the Patient Protection and Affordable Care Act (ACA)) when excessive charges are applied to uninsured or underinsured patients. If abused, tax exempt status can be lost, and loss of exempt status can have serious consequences for hospitals, including (1) imposition of taxes, (2) loss of charitable deductions for donors, (3) loss of local and state tax exemptions, (4) loss of the ability to use tax-exempt financing, (5) loss of exemption from federal unemployment taxes, (6) inability to issue tax exempt bonds, (7) ineligibility for special employee pension plans, and (8) loss of special postal rates.[169] So, for many hospitals, tax-exempt status is critical and there are approximately 5,100 tax-exempt hospitals in the U.S.[170]

Generally, tax-exempt entities undertake functions and services that the government would otherwise be required to perform and also tend to enhance community benefits or goals—so the tax exemption is a type of quid pro quo benefit to offset the savings to the government provided by the entity's charitable purpose.[171] The benefits received by the community are supposed to offset the loss in tax revenue.[172]

Most hospitals obtain their tax-exemption through Internal Revenue Code (IRC) § 501(c)(3). [173] In the section generally applicable to nonprofit hospitals, § 501(c)(3) says, "Corporations . . . organized and operated exclusively for religious, charitable, scientific, . . . or educational purposes" are listed among those exempt from federal taxation.[174] "Promotion of health" is generally considered to be a charitable purpose for tax purposes, so a

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167. 26 U.S.C. § 501 (2018).

168. *Id.*

169. Jonathan E. Brouk, *501(c)(3) Exempt Institutions—Qualifying for and Maintaining Exemptions*, *in* 1 HEALTH CARE LAW: A PRACTICAL GUIDE § 4.03 (2d ed. 2016).

170. TREASURY INSPECTOR GEN. FOR TAX ADMIN., Ref. Num. 2011-10-085, AFFORDABLE CARE ACT: THE TAX EXEMPT AND GOVERNMENT ENTITIES DIVISION'S PLANNING EFFORTS FOR THE HEALTH CARE REFORM LEGISLATION 5 (2011), https://www.treasury.gov/tigta/auditreports/2011reports/201110085fr.pdf [https://perma.cc/QNW4-LFCC].

171. Provena Covenant Med. Ctr. v. Dep't of Revenue, 925 N.E.2d 1131, 1148 (Ill. 2010) (noting that the "*sine qua nan* of charitable status" is for the hospital to "demonstrate that their activities will help alleviate some financial burden incurred by the affected taxing bodies in performing their governmental functions."); Utah Cty., *ex rel.* Cty. Bd. of Equalization of Utah Cty. v. Intermountain Health Care, Inc., 709 P.2d 265, 268 (Utah 1985) ("These exemptions confer an indirect subsidy and are usually justified as the *quid pro quo* for charitable entities undertaking functions and services that the state would otherwise be required to perform.").

172. *Provena Covenant Med. Ctr.*, 925 N.E.2d at 1150.

173. Brouk, *supra* note 169.

174. 26 U.S.C. § 501(c)(3) (2018).

nonprofit hospital organization providing hospital care "may, therefore, qualify as organized and operated in furtherance of a charitable purpose" and thus, qualify for tax-exemption if it meets § 501(c)(3)'s other requirements.[175] The IRS set a "community benefit standard" for § 501(c)(3) whereby "hospitals can be tax exempt if various factors demonstrate that the 'hospitals operate exclusively to the benefit of the community.'"[176]

Section 9007 of the ACA[177] led to IRC § 501(r), which requires that the country's approximately 5,100 tax-exempt hospitals treat eligible uninsured and out-of-network patients more fairly, including discounting of chargemaster charges under some circumstances—or else, the hospital's tax-exempt status may be revoked or they may face other penalties.[178] Section 501(r)(1) says that a hospital "*shall not be treated as [a 501(c)(3) tax-exempt entity]*" unless it meets the additional requirements of § 501(r).[179]

The IRC provides for mandatory review by the Secretary of the Treasury "at least once every three years [of] the community benefit activities of each [501(c)(3)] hospital."[180] The "ACA Review of Operations" group within the Tax-Exempt/Government-Entities Division of the IRS is responsible for performing the reviews.[181] Specifically, 26 U.S.C. § 501(r) places additional requirements on § 501(c)(3) tax-exempt hospitals that the Secretary of the Treasury must review including (1) conducting a "Community Health Needs Assessment" (CHNA) every three years considering input from "persons who represent the broad interests of the community" and making the CHNA "widely available to the public"[182]; (2) meeting the "Financial Assistance

175. Rev. Rul. 69-545, 1969-2 C.B. 117 (1969) (citing RESTATEMENT (SECOND) OF TRUSTS, §§ 368, 372 (AM. LAW INST. 1959); IV SCOTT ON TRUSTS §§ 368, 372 (3d ed. 1967)).

176. St. David's Health Care Sys. v. United States, 349 F.3d 232, 235 (5th Cir. 2003); *see also* Rev. Rul. 69-545, 1969-2 C.B. 117 (1969).

177. Patient Protection and Affordable Care Act of 2010, Pub. L. No. 111-148, 124 Stat. 119 (2018).

178. Memorandum from Fla. Legal Services to the I.R.S. Exempt Orgs. Classification 3 (Aug. 25, 2014) https://9kqpw4dcaw91s37kozm5jx17-wpengine.netdna-ssl.com/wp-content/uploads/2014/08/IRS-Complaint-8.25.14.pdf [https://perma.cc/D5TT-AS6G] ("For the first time, the federal law requires that tax exempt hospitals have reasonable billing and collection requirements to ensure fairness and help reduce the existence and threat of medical debt that prevents many poor people in the community from ever seeking care.").

179. 26 U.S.C. § 501 (r)(1) (2018).

180. Patient Protection and Affordable Care Act of 2010, *supra* note 177, at § 9007 (c) ("The Secretary of the Treasury or the Secretary's delegate *shall review at least once every 3 years* the community benefit activities of each hospital organization to which section 501(r) of the Internal Revenue Code of 1986 [subsec. (r) of this section] (as added by this section) applies.") (emphasis added); TREASURY INSPECTOR GEN. FOR TAX ADMIN., *supra* note 170, at 6 (noting that the IRS must review the "community benefit activities of tax-exempt hospitals at least once every 3 years").

181. TREASURY INSPECTOR GEN. FOR TAX ADMIN., *supra* note 170, at 6.

182. 26 U.S.C. § 501 (r)(3) (2018).

Policy" (FAP) requirements by having a written and widely publicized FAP providing (a) eligibility requirements for financial assistance, (b) the method for applying for financial assistance, (c) "*the basis for calculating amounts charged to patients*," (d) the actions the hospital will take if there is non-payment, and (e) other requirements[183]; (3) meeting limitation on charges requirements including (a) *"limit[ing] the amounts charged* for emergency or other medically necessary care provided to individuals eligible for assistance under the [hospital's] financial assistance policy," (b) limits charges to "not more than the "*amounts generally billed*" [AGB] to individuals who have insurance covering such care, and (c) specifically "*prohibit*[*ing*] *the use of gross* [*chargemaster*] *charges*"[184]; and finally, (4) not "engag[ing] in extraordinary collection actions before the [hospital] has made reasonable efforts to determine whether the individual is eligible for assistance under the financial assistance policy."[185] Thus, § 501(r) specifically prohibits § 501(c)(3) tax-exempt hospitals from charging eligible patients (under the hospital's FAP) full chargemaster rates and limits charges to those patients to no more than the "amounts generally billed" to insured individuals.[186]

The IRS has already begun to take some action as a result of the required audits. Hospitals' § 501(c)(3) status can be revoked for failure to provide community benefit by placing limitations on hospital charges to eligible patients.[187] Specifically, "a hospital organization failing to meet one or more of the requirements of § 501(r) separately with respect to one or more hospital facilities it operates may have its § 501(c)(3) status revoked as of the first day of the taxable year in which the failure occurs."[188] In February 2017, the IRS revoked the tax-exempt status of a hospital for the first time for failure to meet the requirements of § 501(r); specifically, the IRS found "egregious failures" by a hospital to fulfill its duties under § 501(r) because the hospital "failed to adequately meet all of the requirements [of § 501(r)] . . . by not completing and adopting an Implementation Strategy . . . and by not making

183. *Id.* § 501 (r)(4) (emphasis added).
184. *Id.* § 501 (r)(5).
185. *Id.* § 501 (r)(6).
186. 26 C.F.R. § 1.501(r)-1(b)(16) (2019); *see also* 26 C.F.R. § 1.501(r)-5 (2019) (noting that the IRS rules allow the hospital to choose one of three methods to calculate AGB—none of which mention chargemaster or list prices—with all based on Medicare, Medicaid, or private insurer rates.).
187. 26 C.F.R. § 1.501(r)–2(a) (2019).
188. *Id.*

the CHNA report widely available to the public as required by [§ 501(r)]."[189] At least one other hospital has also had their § 501(c)(3) status revoked for failure to comply with § 501(r).[190] In 2017, the IRS revoked the tax-exempt status of another hospital, fined hospitals in Texas and New Jersey, and found "about forty percent of hospitals reviewed by the IRS have received follow-up request for more information."[191]

Section 501(r) provides sanctions short of § 501(c)(3) status revocation as well, including civil monetary penalties (CMP) and temporary suspension of tax-exempt status. A $50,000 CMP is imposed in Section 4959 if the hospital fails to meet the CHNA requirements for the taxable year for each of the hospital's facilities that is out of compliance.[192] In addition to the penalties, if tax-exempt status is temporarily revoked, the facility will have to pay taxes for the affected years.[193]

In addition to the required wide publication of hospitals' CHNA and FAP, non-profit hospitals' tax returns are also public and may provide important information to patients affected by aggressive chargemaster charges. Income Tax Form 990 Schedule H, which is filed by tax-exempt hospitals, "provides a section for tax-exempt hospitals to describe their policies and activities in accordance with the new requirements, including new questions addressing the financial assistance, emergency medical care, and billing and collection policies of tax-exempt hospitals."[194] Each tax-exempt hospital's Form 990 is available online to the public for review of its reporting to the IRS on this matter.

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189. Letter from Mary A. Epps, Acting Dir., Exempt Orgs. Examinations, Internal Revenue Service, No. 201731014, (Feb. 14, 2017), https://www.irs.gov/pub/irs-wd/201731014.pdf [https://perma.cc/N4SH-EZQW]; *see also* Gerald M. Griffith, Catherine E. Livingston & Courtney A. Carrell, *IRS Revokes Hospital's Exempt Status for Failing to Comply with § 501(r)(3)*, JONES DAY (Sept. 1, 2017), https://www.jonesday.com/files/Publication/8f7c9de6-5057-4d88-bebd-6770d46cd10b/Presentation/PublicationAttachment/58f2e216-bd71-45c1-8d2f-70c31a707ab0/AHLA%20Weekly.pdf [https://perma.cc/ZGQ3-7ASC].

190. Letter from Maria Hooke, Dir., Exempt Orgs. Examinations, Internal Revenue Service, No. 201829017, (Apr. 20, 2018), https://www.irs.gov/pub/irs-wd/201829017.pdf [https://perma.cc/XWG5-RTNN]; R. Todd Greenwalt & Brian P. Teaff, *Hospital Loses Its Section 501(c)(3) Status Due to Noncompliance with Section 501(r)*, NAT'L L. REV. (Nov. 3, 2018), https://www.natlawreview.com/article/hospital-loses-its-section-501c3-status-due-to-noncompliance-section-501r [https://perma.cc/QQL9-SY4P].

191. Jonathan Wiik, *The IRS is Going After 501(r) Violations*, BECKER'S HEALTH IT & CIO REP. (Apr. 12, 2018), https://www.beckershospitalreview.com/healthcare-information-technology/the-irs-is-going-after-501-r-violations-here-s-how-to-stay-out-of-trouble.html [https://perma.cc/9GVF-QN72].

192. Erica Clausen & Abbey Hendricks, *Cultivating the Benefit of § 501(r)(3): § 501(r)(3) Requirements for Nonprofit Hospitals*, 20 LEWIS AND CLARK L. REV. 1025, 1038 (2016).

193. *Id.* at 1039.

194. TREASURY INSPECTOR GEN. FOR TAX ADMIN., *supra* note 170, at 6.

Individual patients, attorneys, and groups of legal activists can help address this issue (1) by reporting noncompliance with § 501(r) to the IRS, and (2) arguably by utilizing an implied right of action present in § 501(r). First, "members of the public" may file a complaint on IRS Form 13909, Tax-exempt Organization Complaint (Referral) Form with the IRS Exempt Organizations (EO) Classification office and may even apply for an award for original information.[195] The complaint can be accompanied by supporting information (such as a memorandum) providing details of the hospital's failure to comply with § 501(r).[196]

However, as Form 13909 notes, "Federal law prohibits the IRS from providing you with status updates or information about specific actions taken in response to the information you submit," so the person filing the report will not be informed of the outcome of the IRS evaluation of the particular form.[197] The IRS "has discretion as to how to handle [the complaint] and all actions are kept strictly confidential, even from the complainants."[198] Further, the IRS notes that filers may "also want to send a copy of the referral . . . to [their] state charity regulator and/or state tax agency" and provides links to websites with links to appropriate authorities in each state.[199] As noted below, some states and counties are becoming more aggressive in revoking tax-exempt status for hospitals.

For example, Florida Legal Services (FLS) and the National Health Law Program filed the first such complaint against Jackson Health System in the

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195. *Form 13909: Tax-Exempt Organization Complaint (Referral)*, INTERNAL REVENUE SERV., https://www.irs.gov/pub/irs-pdf/f13909.pdf [https://perma.cc/R8RP-E73R]; *Form 211: Application for Award for Original Information*, INTERNAL REVENUE SERV., https://www.irs.gov/pub/irs-pdf/f211.pdf [https://perma.cc/8NKX-97NC]; *IRS Complaint Process: Tax-Exempt Organizations*, INTERNAL REVENUE SERV., https://www.irs.gov/charities-non-profits/irs-complaint-process-tax-exempt-organizations [https://perma.cc/CQL2-ZBVR] (last updated Feb. 21, 2019) ("Members of the public may send information that raises questions about an exempt organization's compliance with the Internal Revenue Code to the IRS - EO Referrals, 1100 Commerce Street, MC 4910 DAL, Dallas, TX 75242. They may use Form 13909, *Tax-Exempt Organization Complaint (Referral) Form*, for this purpose.").

196. *Complaint Filed with IRS Concerning IRC § 501(r) Compliance*, WITHUM (Sept. 23, 2014), https://www.withum.com/resources/complaint-filed-irs-concerning-irc-§501r-compliance/ [https://perma.cc/P4UN-292F].

197. *Form 13909: Tax-Exempt Organization Complaint (Referral)*, INTERNAL REVENUE SERV., https://www.irs.gov/pub/irs-pdf/f13909.pdf [https://perma.cc/R8RP-E73R].

198. WITHUM, *supra* note 196.

199. *IRS Complaint Process: Tax-Exempt Organizations*, INTERNAL REVENUE SERV., https://www.irs.gov/charities-non-profits/irs-complaint-process-tax-exempt-organizations [https://perma.cc/CQL2-ZBVR] (last updated Feb. 21, 2019); NAT'L ASS'N OF ST. CHARITY OFFICIALS, http://www.nasconet.org/resources/ [https://perma.cc/5ZQG-QYMA] (for referral to state charity regulators); *State Links for Exempt Organizations*, INTERNAL REVENUE SERV., https://www.irs.gov/charities-non-profits/state-links [https://perma.cc/5P2C-BA7A] (to report to state tax agencies).

Miami/Dade County area.[200] FLS represents low-income Floridians on issues including healthcare access and "advancing health rights of low-income and underserved individuals."[201] In the memorandum, FLS notes that "[u]nder the ACA, nonprofit hospital organizations shall not be treated as tax exempt unless they meet specific requirements ensuring that patients and advocates are able to navigate complex financial assessment systems in a fair and uniform manner and not be subject to certain billing and collection practices."[202] FLS also notes that "[f]or the first time, the federal law requires that tax exempt hospitals have reasonable billing and collection requirements to ensure fairness and help reduce the existence and threat of medical debt that *prevents many poor people in the community from ever seeking care*."[203] FLS also states that due to Jackson's noncompliance "many . . . uninsured patients will likely continue to . . . forgo necessary medical care to avoid a medical debt or be subjected to billing practices that violate the ACA."[204] FLS also states that the "ACA . . . requires a tax exempt hospital to widely publicize its FAP" and points out that the "IRS proposes four publication measures: (1) through the hospital's website; (2) through paper distribution; (3) through conspicuous public displays in the facility; and (4) through community notices designed to reach those patients who most likely require financial assistance."[205]

Members of the public can also file complaints with state agencies (e.g., the state attorney general's office) and local agencies that have the power to revoke local tax exemptions. Further, local authorities can challenge tax exemptions in court. Courts are becoming more aggressive in taking action against nonprofit hospitals for aggressive collection practices—which may eventually extend to exorbitant chargemaster charges. For example, one Illinois hospital was stripped of its local property tax exemption when challenged by the county due to its aggressive collection practices from poor patients.[206] Two of the factors considered by the court were whether the

200. WITHUM, *supra* note 196. FLS is "a Florida non-profit corporation representing low-income Floridians on a variety of issues including health care." *Id.* The National Health Law Program (NHLP) joined FLS in the filing and is "a non-profit organization that protects and advances health rights of low income and underserved individuals." *Id. See generally* https://healthlaw.org [https://perma.cc/UWN3-AC74].

201. WITHUM, *supra* note 196.

202. Memorandum from Fla. Legal Servs. in Support of IRS Form 13909 Tax-Exempt Organization Complaint (Referral) Form (Aug. 25, 2014) https://9kqpw4dcaw91s37kozm5jx17-wpengine.netdna-ssl.com/wp-content/uploads/2014/08/IRS-Complaint-8.25.14.pdf [https://perma.cc/33K8-R8Q3].

203. *Id.* (emphasis added).

204. *Id.*

205. *Id.*; Treas. Reg. §§ 1.510(4)–4(b)(5)(i).

206. Brouk, *supra* note 169.

hospital "dispenses charity to all who need it and apply for it" and that no "obstacles [are placed] in the way of" needy patients.[207] Excessive chargemaster charges applied to uninsured and out-of-network patients likely would violate both of these factors.

By filing these complaints, members of the public and local groups may bring attention to the problems caused by high hospital chargemaster charges and unfair billing practices which may create a public relations issue for the hospitals and shine a light on the problem for members of Congress. As Oliver Wendell Holmes, Jr. observed, "When you get the dragon out of his cave on to the plain and in the daylight, you can count his teeth and claws."[208] It is only fair that the predatory hospital wolves be brought into the sunlight for patients and the public to see. With such political pressure, further action might be taken[209]—like (1) ensuring an express private right of action under § 501(r) as suggested below . . . if an implied right (discussed below) is not already present and (2) placing reasonable limits on the amount hospitals can charge to *all* patients.

Second, a private right of action under § 501(r) may be implied for patients eligible for financial assistance under the individual hospital's FAP against the noncompliant hospital. Most courts agree that patients have "no personal cause of action under 501(c)(3)."[210] Instead, the IRC vests authority for enforcement under § 501(c)(3) in the Secretary of the Treasury.[211]

However, § 501(r) creates new patient specific rights that were not present in § 501(c)(3) that may create a private right of action specific to § 501(r). "In general, a court may infer a private right of action where a statute protects a class of persons without providing a civil remedy, if the implied remedy furthers the legislative purpose and is necessary to ensure the statute's effectiveness."[212] A "private right of action allows a private plaintiff to bring an action based directly on a public statute, the Constitution or federal common law" or "to seek judicial relief from injuries caused by another's

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207. *Provena Covenant Med. Ctr.*, 925 N.E.2d at 1145.

208. Oliver Wendell Holmes, Jr., *The Path of the Law*, 10 HARV. L. REV. 457, 469 (1897).

209. Peyton M. Sturges, *Complaint Filed with IRS by Advocacy Groups Charges Hospital Shuns Charity Obligations*, BLOOMBERG BNA (Sept. 11, 2014) http://op.bna.com.s3.amazonaws.com/hl.nsf/r%3FOpen%3dpsts-9ufll7 [https://perma.cc/ZM2Z-6XM9] (pointing out that "[t]he bigger potential impact may be in a public relations battle or in any attention the situation may garner in Congress").

210. Brouk, *supra* note 169 ("For the most part, courts have held that patients have no personal cause of action under Internal Revenue Code Section 501(c)(3)."). *See, e.g.*, Burton v. William Beaumont Hosp., 347 F. Supp. 2d 486, 489 (E.D. Mich. 2004) (noting "the Hill–Burton Act allows for a private right of action. Section 501(c)(3), however, does not.").

211. *See* 26 U.S.C. § 7801.

212. 1A C.J.S. *Actions* § 63.

violation of a legal requirement."[213] The doctrine of implied rights of action "rest[s] on the English common law principle that for every legal right there is a remedy."[214] "This common law principle was used by John Marshall to decide *Marbury v. Madison*."[215] Congress may place "express" private rights of action into legislation (*see, e.g.*, the Americans with Disabilities Act or the Clayton Antitrust Act), and courts may deduce that Congress intended an "implied" private right of action even though Congress left out an express right of action.[216] As an example, "[i]mplied private rights of action appear in areas as diverse as copyright law, education law, civil rights law, and securities law."[217]

"Private rights of action are an important part of many administrative schemes."[218] "Although these actions are brought on behalf of a particular party, that party is acting as a "private attorney general" and serves to vindicate the public interest."[219] There are multiple instances where the Court has confirmed implied private rights of action; for example, a "vast array of security fraud related actions" are available under SEC rule 10b-5.[220]

Within the IRC, "Congress provides a wide array of rights to redress abusive practices."[221] One author summarized:

> These rights include the right to sue for a refund of taxes, to challenge a deficiency in the United States Tax Court, to receive notice and an opportunity for an administrative hearing prior to the filing of a notice of federal tax lien, to contest the validity of liens, . . . *to have a lien released within thirty days after which the liability for which the lien was filed is satisfied or becomes legally unenforceable*, to have a levy released under similar circumstances . . . *to collect damages for the wrongful failure to*

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213. Caroline B. Newcombe, *Implied Private Rights of Action: Definition, and Factors to Determine Whether a Private Action Will Be Implied from a Federal Statute*, 49 LOY. U. CHI. L.J. 117, 120–21 (2017).

214. *Id.* at 124.

215. *Id.*

216. *Id.* at 125; Schlessinger v. Valspar Corp., 817 F. Supp. 2d 100, 104–05 (E.D.N.Y. 2011); *aff'd*, 723 F.3d 396 (2d Cir. 2013) ("When, as here, a statute does not provide an express private right of action, the courts will imply a private right of action only upon examination of the following three factors: (1) whether the plaintiff is one of the class for whose particular benefit the statute was enacted; (2) whether recognition of a private right of action would promote the legislative purpose; and (3) whether creation of such a right would be consistent with the legislative scheme.") (citations and internal quotation marks omitted).

217. Newcombe, s*upra* note 213, at 119.

218. CHARLES H. KOCH JR. & RICHARD MURPHY, 3 ADMIN. L. & PRAC. § 8:50 (3d ed.).

219. *Id.*

220. *Id.*

221. Christopher M. Pietruszkiewicz, *A Constitutional Cause of Action and the Internal Revenue Code: Can You Shoot (Sue) the Messenger?*, 54 SYRACUSE L. REV. 1, 6 (2004).

> *release tax liens*, to recover damages for the unauthorized enticement of disclosure of taxpayer information, [among others].[222]

The right to sue to have unenforceable liens released and collect damages may imply that a patient has a similar right to sue a § 501(r)-noncompliant hospital for trying to collect an unlawful (and therefore similarly unenforceable) debt under § 501(r). The Supreme Court considers four factors to determine whether Congress intended a private right of action: (1) "whether the statute was enacted for the benefit of a special class of which the plaintiff is a member," (2) whether there is any indication of legislative intent to create a private remedy in the legislative history, (3) whether implication of such a remedy "would frustrate the underlying purpose of the legislative scheme," and (4) "whether implying a federal remedy is inappropriate because the subject matter involves an area basically of concern to the States."[223]

Here, § 501(r) requires nonprofit hospitals to perform a Community Health Needs Assessment (CHNA) and to identify eligible individuals in need of financial assistance under their Financial Assistance Policy (FAP). Therefore, § 501(r) was "enacted for the benefit of a special class of which the [eligible individual under the hospital's FAP] is a member."[224] Therefore, an individual identified by the hospitals CHNA and FAP as being eligible for financial assistance would clearly be a member of the class for whom this special benefit was enacted.

The second factor is fulfilled because the statute clearly places (1) limits upon how much hospitals can charge eligible patients and (2) limits on hospital billing practices with regard to collecting from eligible patients. If Congress did not intend that eligible patients be able to enforce these limits with a private right of action, then it has intentionally created a law that provides no method of enforcement for individual victims by violators of this law—which is contrary to the tradition of English law.[225] That is, if eligible patients who are victims of receiving outrageous chargemaster bills are not able to enforce the law via private right of action, then what is the point of the law at all? Congress intended that its law be enforced and, therefore, impliedly granted the victims of violators a private right to enforce that law.

The third factor is satisfied because a private remedy does not frustrate the underlying purposes of the law, but in fact, helps achieve the statutory

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222. *Id.* at 6–7 (emphasis added).
223. Cannon v. Univ. of Chicago, 441 U.S. 677, 689, 694, 703, 708 (1979).
224. *Id.* at 689.
225. *Id.* at 689, 694, 703, 708.

purpose of protecting individual citizens from discriminatory hospital pricing.

Finally, the fourth factor is satisfied because health care is increasingly an area of concern for the federal government because health care costs have led to increasing federal involvement in health care, as evidenced by the very law in which § 501(r) was included—the ACA. As the *Cannon* court noted, "the Court has long recognized that under certain limited circumstances the failure of Congress to [provide an express private right of action] is not inconsistent with an intent on its part to have [a private right of action] available to the persons benefited by its legislation."[226]

Therefore, IRC § 501(r) "presents the atypical situation in which *all* of the circumstances that the Court has previously identified as supportive of an implied remedy are present," and under § 501(r) patients who are eligible or potentially eligible under a hospital's FAP have a private right of action to at least seek injunctive relief to stop hospitals' attempts to collect unlawful charges under § 501(r) and to seek damages compensating patients for any harm caused by unlawful collection attempts of illegal charges.[227] Because of the obvious harms associated with illegal collection efforts under § 501(r), I believe this analysis demonstrates that Congress had "clearly expressed" (as required in *Alexander v. Sandoval*) an intent to imply a private right of action under § 501(r).[228] If a court finds that there is no private right of action under 501(r), then Congress should clearly establish one immediately.

2. Disparate impact litigation and Office of Civil Rights (OCR) action

Exorbitant chargemaster charges disproportionately impact protected minorities because more minorities are uninsured or out-of-network, which leads to a higher exposure to unfair chargemaster charges. Where excessive hospital chargemaster charges disproportionately exploit protected populations, the Office of Civil Rights (OCR) should step in to address the issue, and attorneys should facilitate administrative complaints as well as pursue civil litigation against offending hospitals with discriminatory chargemaster pricing.

a. Minorities are disparately impacted by exorbitant chargemaster charges

226. *Id.* at 717.
227. *Id.*
228. KOCH & MURPHY, *supra* note 218.

"Emergency room price gouging is worst for minorities," according to a Johns Hopkins University School of Medicine study involving more than 12,000 billing records published in the *Journal of the American Medical Association Internal Medicine* in May 2017.[229] The hospitals with the highest percentages of excess ED charges tend to treat a greater number of uninsured patients and be located in the southeastern U.S.—both factors that lead to a disparate impact on minorities who are more likely to be uninsured and living in the southeastern U.S.[230]

Oppressive chargemaster charges result in discrimination against minorities who are more likely to be uninsured, out-of-network, and have medical conditions that lead to increased exposure to chargemaster charges. First, minorities are more likely to be uninsured and unprotected from the chargemaster by an insurance contract. Specifically, "Hispanics and Blacks have significantly higher uninsured rates (nineteen and eleven percent, respectively) than Whites (seven percent)."[231] Without the protection of an insurance contract, uninsured patients are billed the full chargemaster prices, which leads to the discriminatory practice of minority patients being routinely billed higher prices than white patients for the same services.

Second, minorities are more likely to seek out-of-network medical care than white patients, which makes it more likely that they will be billed full chargemaster rates since they are unprotected by an in-network contract price. There are several reasons minorities are more likely to use out-of-network providers. For example, "involuntary use of out-of-network providers [is] higher among those with lower incomes and whose health status is 'fair' or 'poor,'"[232] and African-Americans have a higher incidence of low income and fair or poor health status[233]—so black patients are more likely to be subject to involuntary use of out-of-network providers and facilities. In addition, hospital location and geography may play a role in involuntary use of out-of-network services by minorities because hospitals tend to locate in white neighborhoods, which results in African Americans'

229. Xu et al., *supra* note 1, at 1139; *Emergency Room Patients Routinely Overcharged, Study Finds: 'Price Gouging' Is Worst for Minorities and Uninsured*, SCIENCE DAILY (May 20, 2017), https://www.sciencedaily.com/releases/2017/05/170530115045.htm [https://perma.cc/X33R-QCZJ].

230. Xu et al., *supra* note 1, at 1139.

231. Cubanski et al., *supra* note 51, at Figure 6.

232. Erin Audrey Taylor & Layla Parast, *A Tale of Two Deliveries, or an Out-of-Network Problem*, THE RAND BLOG (Nov. 4, 2015), https://www.rand.org/blog/2015/11/a-tale-of-two-deliveries-or-an-out-of-network-problem.html [https://perma.cc/8BA6-N6YN].

233. THOMAS E. PEREZ, *The Civil Rights Dimension of Racial and Ethnic Disparities in Health Status*, *in* UNEQUAL TREATMENT: CONFRONTING RACIAL AND ETHNIC DISPARITIES IN HEALTH CARE 626, 630 (Brian D. Smedley et al. eds., 2003).

and other minorities' need to travel farther from home (and, therefore, lead to a higher risk of encountering out-of-network providers).[234]

Likewise, black patients are more likely to access care through emergency departments than white patients,[235] and "[i]npatient admissions" and "[o]utpatient service days" that involve accessing care through the emergency room "are more likely to include claims for an out-of-network provider."[236] Again, lack of providers in black neighborhoods may contribute to this reliance on emergency rooms for access to care.[237] Further, because doctors are less likely to locate their private practices in minority neighborhoods, African-American patients are more likely to seek care in hospital facilities,[238] and "outpatient service days that include a claim in a facility [e.g., a hospital] are more likely to include a claim from an out-of-network provider."[239]

Finally, minorities seeking mental health care suffer discrimination related to unfair chargemaster pricing because "enrollees using outpatient mental health services are significantly more likely to have a claim from an out-of-network provider."[240] Mental health services are disproportionately used by black Americans compared to whites—again leading to disparities

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234. Amitabh Chandra & Jonathan S. Skinner, *Geography and Racial Health Disparities*, *in* CRITICAL PERSPECTIVES ON RACIAL AND ETHNIC DIFFERENCES IN HEALTH IN LATE LIFE 16 (Norman B. Anderson et al. eds., 2004) ("A variety of studies have documented the large differences in insurance status and presence of regular providers (versus emergency room visits) among African Americans, Hispanics, and non-Hispanic whites . . . [and] simple differences in where people live will lead to minority patients being seen at different hospitals, and by different providers, from whites."); INST. OF MED., UNEQUAL TREATMENT CONFRONTING RACIAL AND ETHNIC DISPARITIES IN HEALTH CARE 29 (Brian D. Smedley et al. eds., 2003) ("Significantly, minorities' access to better quality facilities is often limited by the geographic distribution of care facilities and patterns of residential segregation, which results in higher-quality facilities being less accessible to minorities."); Sidney D. Watson, *Section 1557 of the Affordable Care Act: Civil Rights, Health Reform, Race, and Equity*, 55 HOW. L.J. 855, 864–70 (2012) ("Physicians and hospitals both tend to avoid minority neighborhoods because residents tend to be poorer and more likely to be either uninsured or covered by Medicaid.").

235. INST. OF MED., *supra* note 234, at 29 ("Hispanic and African-American patients are also more likely to receive care in hospital emergency rooms and are less likely than whites to have a regular primary care provider.").

236. Gary Claxton et al., *An Analysis of Out-of-Network Claims in Large Employer Health Plans*, PETERSON-KAISER HEALTH SYSTEM TRACKER, BRIEFS ACCESS AND AFFORDABILITY, (Aug. 13, 2018), https://www.healthsystemtracker.org/brief/an-analysis-of-out-of-network-claims-in-large-employer-health-plans/#item-start [https://perma.cc/5GUN-GWM7].

237. INST. OF MED., *supra* note 234, at 143 ("Significantly, minorities' access to better quality facilities is often limited by the geographic distribution of care facilities and patterns of residential segregation . . . , which results in higher-quality facilities being less accessible to minorities.").

238. *See id.* at 29.

239. Claxton et al., *supra* note 236.

240. *Id.* (observing a "high incidence of out of network provider claims among enrollees using mental health services").

caused by chargemaster charges; specifically, black Americans are "20[%] more likely to report serious psychological distress than adult whites,"[241] and "Black/African American teenagers are more likely to attempt suicide than are white teenagers (8.3[%] v. 6.2[%])."[242] Further, African-Americans are more likely to be victims of serious crime, suffer from PTSD, and be diagnosed with schizophrenia.[243] Thus, for numerous reasons, African-Americans are more likely to face bills reflecting full chargemaster charges from out-of-network providers than white patients—again, demonstrating disparate impact of excessive chargemaster prices on protected minority populations.

The results of discriminatory chargemaster pricing may be reflected in bankruptcy filings. Minorities have more problems with paying medical bills with 24% of white, non-Hispanics saying they or someone in their family were having problems paying medical bills within the past twelve months compared to 31% of blacks and 32% of Hispanics.[244] Medical expenses play a major role in bankruptcy filings.[245] African-Americans are more likely to file for bankruptcy than whites and are "about twice" as likely to end up filing for the "more onerous and costly form of consumer bankruptcy" (i.e., Chapter 13) than whites.[246] Discriminatory pricing related to excessive chargemaster charges for medical bills may contribute to this trend.

b. OCR can address disparate impact caused by excessive chargemaster charges

Title VI of the Civil Rights Act of 1964 applies to hospitals receiving federal financial assistance (basically all hospitals since they all take Medicare) and prohibits discrimination based on race, color, or national

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241. *Black and African-American Communities and Mental Health*, MENTAL HEALTH AM., http://www.mentalhealthamerica.net/african-american-mental-health [https://perma.cc/D8VA-2CTE].

242. *Id.*

243. *Id.*

244. Liz Hamel et al., *The Burden of Medical Debt: Results from the Kaiser Family Foundation/New York Times Medical Bills Survey*, KAISER FAMILY FOUND., (Jan. 5, 2016), https://www.kff.org/report-section/the-burden-of-medical-debt-appendix// [https://perma.cc/GQ55-Q4QG].

245. A. Mechele Dickerson, *Race Matters in Bankruptcy*, 61 WASH. & LEE L. REV. 1725, 1739 (2004) ("Scholars . . . agree that . . . uninsured medical expenses . . . cause people to seek bankruptcy relief."); Jacoby et al., *supra* note 16, at 377 ("Nearly half of *all* bankruptcies involved a medical problem . . . .").

246. Tara Siegel Bernard, *Blacks Face Bias in Bankruptcy, Study Suggests*, N.Y. TIMES (Jan. 20, 2012), https://www.nytimes.com/2012/01/21/business/blacks-face-bias-in-bankruptcy-study-suggests.html [https://perma.cc/R6Z7-MSJH].

origin.[247] In addition to intentional discrimination, Title VI applies to health care practices or policies that disparately impact minorities causing discriminatory effects.[248] The Office of Civil Rights (OCR) enforces Title VI, and private litigation is also available in limited circumstances (i.e., intentional discrimination and possibly under ACA's section 1557—as discussed below).[249]

Disparate impact discrimination is defined under Title VI as "policies or practices that may be neutral on their face but have the *effect* of discriminating on the basis of race, color, or national origin."[250] In a disparate impact claim, "[t]he issue is whether a challenged practice has sufficient adverse racial impact—in other words, whether it falls significantly more harshly on a minority racial group than on the majority—and, if so, whether the practice is nevertheless adequately justified."[251] Title VI applies to discriminatory concerns in health care like diminished access to health services for minorities caused by inequalities in the prices charged by hospitals to minority patients compared to nonminority patients.[252]

OCR can take administrative action based upon disparate impact and has a broad range of power to challenge discriminatory practices.[253] OCR could demand that the HHS Commissioner address this disparate impact by requiring hospitals that receive federal funding to bill everyone an amount that is in line with the amounts that they reasonably and customarily expect to actually be paid.[254]

c. Civil litigation by patients for discriminatory hospital pricing may be an option

Alexander v. Sandoval limited private cause of action under Title VI to intentional discrimination—which would be difficult to prove with regard to exorbitant chargemaster charges.[255] However, section 1557 of the ACA may reopen that door by "prohibit[ing] discrimination on the basis of race, color,

247. 42 U.S.C. § 2000(d) (2018); 45 C.F.R. § 80.3(b)(2) (2019).

248. 45 C.F.R. § 80.3(b)(2).

249. 42 U.S.C. § 2000(d).

250. PEREZ, *supra* note 233, at 630; *see generally* Alexander v. Sandoval, 532 U.S. 275 (2001).

251. Lucero v. Detroit Pub. Sch., 160 F. Supp. 2d 767, 788 (E.D. Mich. 2001).

252. PEREZ, *supra* note 233, at 630.

253. *Id.* at 630–31 (describing OCR's involvement in numerous different types of discrimination); *see* Thomas Perez, Dir., Office for Civil Rights, Discrimination and Health Disparities, Speech (Apr. 13, 1999).

254. *See generally* Nondiscrimination in Health Programs and Activities, 81 Fed. Reg. 31,375 (May 18, 2016) (to be codified at 45 C.F.R. pt. 92).

255. *See Sandoval,* 532 U.S. at 293 (holding that no private right of action exists to enforce disparate impact regulations under Title VI).

national origin, sex, age, or disability in certain health programs and activities."[256] Section 1557 "provides that . . . an individual shall not, on the grounds prohibited under Title VI of the Civil Rights Act of 1964 . . . be subjected to discrimination under, any health program or activity, any part of which is receiving Federal financial assistance."[257]

Under section 1557 individuals may sue in federal court. HHS has interpreted section 1557 as providing "a new, health-specific, anti-discrimination cause of action that is subject to a singular standard, regardless of the plaintiff's protected class," which is important because it may allow for a private cause of action even where one is not available based on the underlying *Sandoval* issue in Title VI.[258] However, the Court has not determined the "precise standard" that applies to section 1557."[259]

Section 1557 covers virtually all health care entities—including "'any health program or activity, *any part* of which is receiving Federal financial assistance, including credits, subsidies, or contracts of insurance,' or 'any program or activity that is administered by an Executive Agency or any entity established under this title (or amendments).'"[260] Therefore, if any part of an organization receives federal funding or subsidies, then the entire organization is subject to section 1557's anti-discrimination requirements—which includes virtually all hospitals, since virtually all receive federal assistance (e.g., through Medicare or other federal programs).

Therefore, minorities affected by discriminatory pricing resulting from being charged full chargemaster rates more frequently than nonminority patients can sue for relief under section 1557 of the ACA.

3. Targeting monopoly hospitals' exorbitant chargemaster prices with antitrust laws

Antitrust laws can be used to target monopoly hospitals that charge excessive chargemaster prices. The federal antitrust statutes are enforced by

256. 45 C.F.R. § 92.1 (2016); 42 U.S.C. § 18116 (2010) ("[A]n individual shall not, on the ground prohibited under title VI of the Civil Rights Act of 1964 . . . be subjected to discrimination under, any health program or activity, any part of which is receiving Federal financial assistance . . . .").

257. 42 U.S.C. § 18116.

258. Rumble v. Fairview Health Servs., No. 14-CV-2037 (SRN/FLN), 2015 WL 1197415, at *11 (D. Minn. Mar. 16, 2015); *see also* Watson, *supra* note 234, at 864–70 ("Section 1557 of the ACA creates a new health-specific anti-discrimination prohibition that reaches further than Title VI, prohibiting discrimination not only in federally funded health programs but also federally administered health programs and new ACA-authorized entities like Exchanges.").

259. *Rumble*, 2015 WL 1197415, at *12.

260. *Id.* at *7 (emphasis added).

the antitrust division of the Department of Justice, the Federal Trade Commission, the State Attorneys General, and sometimes by injured parties.[261] All states have their own antitrust laws with most modeled after the federal laws and many state courts even noting that federal case precedents apply in interpreting the state versions.[262] The FTC is an independent regulatory agency whose purpose is to prevent unfair competition and deceptive practices.[263]

The antitrust laws apply to nonprofit hospitals. "The Supreme Court has stated that it is 'beyond debate that nonprofit organizations can be liable under the antitrust laws.'"[264] This is important because in 2019 almost 70% of non-governmental community hospitals are organized as nonprofit organizations.[265] Theoretically, nonprofit status can lead to a lack of incentive of organizations to gain market share, which has major implications in antitrust law.[266] Antitrust laws prevent a limited number of firms from obtaining "market power" and exerting exclusionary conduct that can affect the whole market.[267] When a firm obtains market power, it can unilaterally decide to raise prices and lower quality.[268] Market share and market concentration are the primary indicia of market power.[269]

The antitrust Agencies have noted that the "best available evidence shows that the pricing behavior of nonprofits when they achieve market power does not systematically differ from that of for-profits," and consequently, "nonprofit status of a hospital should not be considered in determining whether a proposed hospital merger violates the antitrust laws."[270] A monopoly is present when a firm has market power so that it can significantly raise and sustain price above its competitors without losing enough business to force it to rescind its price increases.[271]

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261. JOHN J. MILES, HEALTH CARE & ANTITRUST LAW § 1:3 (2019).

262. *Id.*

263. *Id.*

264. MARILYN E. PHELAN, NONPROFIT ORGANIZATIONS: LAW AND TAXATION § 14:29 (2d ed. 2019).

265. *Fast Facts on U.S. Hospitals, 2019*, AM. HOSP. ASS'N, https://www.aha.org/statistics/fast-facts-us-hospitals [https://perma.cc/C792-VQJV] (*2968 nongovernment not-for-profit community hospitals + 1322 for-profit community hospitals = total of 4290*; *2968/4290 = 69%*).

266. MILES, *supra* note 261, at § 1:5.

267. *Id.* at § 1:2.

268. *Id.*

269. *Id.* at § 1:4.

270. FED. TRADE COMM'N & DEP'T OF JUSTICE, IMPROVING HEALTH CARE: A DOSE OF COMPETITION (2004), https://www.ftc.gov/sites/default/files/documents/reports/improving-health-care-dose-competition-report-federal-trade-commission-and-department-justice/040723healthcarerpt.pdf [https://perma.cc/787T-DDJB].

271. MILES, *supra* note 261, at §1:4.

The Sherman Act was enacted in 1890 and is intended to be a "comprehensive charter of economic liberty aimed at preserving free and unfettered competition as the rule of trade."[272] Section 2 of the Sherman Act criminalizes monopolization, attempted monopolization, and conspiracies to monopolize saying, "Every person who shall monopolize, or attempt to monopolize, or combine or conspire with any other person or persons, to monopolize any part of the trade or commerce among the several States . . . shall be deemed guilty of a felony . . . ."[273] Monopoly power is defined as "the power to control prices or exclude competition."[274] The Sherman Act prohibits antitrust conduct that is inconsistent with the public welfare—like price fixing.[275] Because the Sherman Act regulates interstate "commerce," courts examine the practices of hospitals to determine whether an activity involved commercial activity, and the current tendency is for courts to "find commercial involvement" and sometimes "impose liability under the act without finding a direct involvement in commerce."[276]

Section 7 of the Clayton Act also includes prohibitions against monopolization saying, "No person engaged in . . . any activity affecting commerce shall acquire . . . [stock or assets] . . . in any line of commerce . . . [if] the effect of such acquisition may be substantially to lessen competition, or to tend to create a monopoly."[277] The FTC is likely to "aggressively target the health care industry" in the next few years with merger challenges and antitrust enforcement actions.[278] In a recent merger challenge, the FTC and Idaho state authorities successfully argued that the acquisition of a large physician group by a hospital system would result in market power leading to higher costs with the court holding that the acquisition violated section 7 of the Clayton Act.[279] This transaction was valued at only $16 million, which is below the level that requires a Hart–Scott–Rodino Act filing, and shows that the FTC is more aggressively pursuing these mergers, and also shows the FTC's apparent new interest in

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272. N. Pac. Ry. Co. v. United States, 356 U.S. 1, 4 (1958).

273. 15 U.S.C. § 2 (2018); MILES, *supra* note 261, at § 1:3.

274. United States v. E. I. du Pont de Nemours & Co., 351 U.S. 377, 391 (1956); *see also* Morris Commc'ns Corp. v. PGA Tour, Inc., 364 F.3d 1288, 1294 (11th Cir. 2004).

275. PHELAN, *supra* note 264, §14:29 n.11 ("If the challenged conduct is inconsistent with the public welfare, the per se rules will cause the practices to fall under the prohibitions of the Sherman Act.").

276. *Id.* at § 14.29.

277. 15 U.S.C. § 18 (2018).

278. Lesli Esposito & Brian J. Boyle, *Antitrust Health Care Trends to Watch in 2015*, LEGAL INTELLIGENCER (Feb. 17, 2015, 12:00 AM), https://www.law.com/thelegalintelligencer/almID/1202717740168/Antitrust-Health-Care-Trends-to-Watch-in-2015/?slreturn=20190723160253 [https://perma.cc/763Y-9TBK].

279. *Id.*

vertical transactions where they have traditionally focused on horizontal transactions between competitors.[280]

High chargemaster charges are evidence of monopoly power actionable under antitrust laws. The key question in any antitrust analysis is whether the conduct harms consumers, and the true test is whether the conduct affects the market as a whole.[281] In other words: Does the firm's conduct give it market power that it may use to harm consumers and the market as a whole?[282] If so, the antitrust laws are intended to prohibit that type of conduct.

In a recent study of insurance claims data, "monopoly hospitals" (defined in the study as having no competitors within a fifteen mile radius) charged prices that were 12% higher than hospitals in markets with four or more competitors.[283] In addition, monopoly hospitals "load more risk on insurers (e.g., they have more cases with prices set as a share of their charges),"[284] which leads to patients having to pay prices based on inflated chargemaster charges more frequently. More specifically, monopoly hospitals have 10% more cases paid as a percent of charges compared to quadropoly hospitals.[285] Monopoly hospitals use bargaining leverage when negotiating prices with insurers.[286] Further evidence of monopoly power of hospitals is the fact that merger of geographically close hospitals leads to price increases of around 6%.[287]

The FTC and DOJ should target monopoly hospitals with exorbitant chargemaster charges on antitrust grounds.

In addition, states' attorneys general should get involved in pursuing monopoly hospitals with exorbitant chargemaster rates. In January 2010, the Massachusetts Attorney General released a study entitled "Investigation of Health Care Cost Trends and Cost Drivers" that found that:

> . . . price variations are not correlated to (1) quality of care, (2) the sickness or complexity of the population being served, (3) the extent to which a provider is responsible for caring for a large portion of patients on Medicare or Medicaid, or (4) whether a provider is an academic teaching or research facility. Moreover, (5) price

280. *Id.*
281. MILES, *supra* note 261, at § 1:2.
282. *Id.*
283. Zach Cooper, et al., *The Price Ain't Right? Hospital Prices and Health Spending on the Privately Insured*, 134 Q.J. ECON. 51, 51 (2018).
284. *Id.*
285. *Id.* at 103.
286. *Id.* at 57.
287. *Id.* at 55.

> variations are not adequately explained by differences in hospital costs of delivering similar services at similar facilities.[288]

Instead, "prices were correlated with market leverage as measured by the relative market position of the hospital or provider group compared with other hospitals or provider groups within a geographic region, or within a group of academic medical centers." [289] Similarly, the Rhode Island Department of Insurance and the Center for Studying Health System Change noted the "imbalance in negotiating leverage" involving large "multihospital provider systems."[290]

Thus, federal and state authorities should pursue antitrust actions against monopoly hospitals with exorbitant chargemaster charges. An extended discussion of antitrust law as it applies to hospital pricing is beyond the scope of this article.

B. Proposed New Federal Policy Protections

Politicians, experts, and ordinary Americans agree that legislation is needed to protect patients from hospitals' "practice of charging patients for care that is more expensive than anticipated or not covered by their insurance." [291] Politicians from both parties support addressing this problem. [292] Republican President Donald Trump recently promised that "[w]e're going to stop all of it" and called for a solution with "the biggest teeth you can find."[293] Democratic House Speaker Nancy Pelosi's spokesman recently stated that "[e]nding surprise billing is an important part of Democrats' ongoing effort to lower out-of-pocket health costs, and we'll be

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288. Robert A. Berenson, *Acknowledging the Elephant: Moving Market Power and Prices to the Center of Health Policy*, HEALTH AFF. BLOG (June 3, 2014), https://www.healthaffairs.org/do/10.1377/hblog20140603.039332/full/ [https://perma.cc/MJV6-GW7V].

289. *Id.*

290. *Id.*

291. *Trump Targets Surprise Medical Billing as Administration Pushes for More Transparency in Health Care Pricing*, KAISER HEALTH NEWS: MORNING BRIEFING (Jan. 24, 2019), https://khn.org/morning-breakout/trump-targets-surprise-medical-billing-as-administration-pushes-for-more-transparency-in-health-care-pricing/ [https://perma.cc/BYV9-T8LP].

292. Susannah Luthi, *Trump Vows to End Balance Billing*, MOD. HEALTHCARE (Jan. 23, 2019), https://www.modernhealthcare.com/article/20190123/NEWS/190129980/trump-vows-to-end-balance-billing [https://perma.cc/9VGT-XD4D].

293. KAISER HEALTH NEWS, *supra* note 291.

working on it in the coming Congress."[294] One senator noted, "[f]ar too many Americans know what it's like to receive an exorbitant health care bill and not know how they're going to pay for it" and lamented the "unacceptable" and "difficult financial sacrifices" forced upon families "throughout the nation" by the practice of surprise hospital billing.[295] Another senator said "massive surprise medical bills" are "unacceptable" and being increasingly faced by consumers.[296]

Experts who have studied the issue report that a national solution is needed. After an extensive nationwide study of emergency department charges, researchers concluded that "further legislation is needed to protect uninsured and out-of-network patients from excess charges in the emergency department."[297] The authors concluded that "now, more than ever, protecting uninsured and out-of-network patients from highly variable hospital pricing should be a policy priority"[298]—concluding "a national model is necessary to unveil what is currently an inexplicably chaotic and opaque pricing system."[299] Another expert explains that "[t]he story of our unchecked health care spending in the U.S. is a story about high and undisciplined prices . . . . driven at its core by a growing provider monopoly problem" and suggests that only regulation can solve the problem.[300]

Consumer groups are also fed up. One consumer rights group chair notes, "We hear about it all the time—astronomical out-of-network charges that bankrupt families—and it's unacceptable."[301] Nine organizations—including consumers, health insurance companies, and businesses—recently announced their support for "federal legislation to protect patients from

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294. Shefali Luthra & Emmarie Huetteman, *Ideas to o Curb Surprise Medical Bills Percolate With Rare Bipartisan Push*, KAISER HEALTH NEWS (Feb. 5, 2019), https://khn.org/news/ideas-to-curb-surprise-medical-bills-percolate-with-rare-bipartisan-push/ [https://perma.cc/T3P8-WX5G].

295. Press Release, Maggie Hassan, U.S. Senator for N.H., Shaheen & Hassan to Each Introduce Legislation to Combat Escalating Out-of-Pocket Health Care Costs, Stabilize Health Care Marketplace & End Surprise Medical Bills (Oct. 3, 2018), (available at https://www.hassan.senate.gov/news/press-releases/shaheen-and-hassan-to-each-introduce-legislation-to-combat-escalating-out-of-pocket-health-care-costs-stabilize-health-care-marketplace_end-surprise-medical-bills [https://perma.cc/LL5P-NNGW]).

296. *Id.*

297. Xu et al., *supra* note 1, at 1140.

298. *Id.* at 1144.

299. SCIENCE DAILY, *supra* note 229.

300. Erin Fuse Brown, *How To Fix Our Hospital Pricing Problem (and How Not To)*, BILL HEALTH (Apr. 16, 2015), http://blog.petrieflom.law.harvard.edu/2015/04/16/how-to-fix-our-hospital-pricing-problem-and-how-not-to/ [https://perma.cc/QEL3-XUZY].

301. Press Release, Maggie Hassan, *supra* note 295.

receiving surprise medical bills."[302] The four guiding principles advocated by this group included "[p]rotecting patients from surprise medical bills through federal legislation," "[i]nforming patients when care is out of network," "[c]reating federal policies that restrain costs and ensure quality networks," and "[u]sing a federal standard when deciding on payments to out-of-network doctors."[303]

Recently, several bills have been proposed to address hospital pricing issues. Commonalities between the proposals and some additional ideas will be discussed in this section.

1. Placing a ceiling on hospital chargemaster prices

Multiple proposals are currently being considered to place a ceiling on hospital charges in some cases. In October 2018, the Reducing Costs for Out-of-Network Services Act of 2018 was introduced by Senator Jeanne Shaheen (D-NH) and would place a maximum rate cap (ceiling) on the amount that hospitals and doctors can charge out-of-network and uninsured patients who would otherwise face chargemaster prices.[304] The bill places "[l]imitation[s] [o]n [c]harges [b]y [h]ealth [c]are [p]roviders" such that the "health care provider may not charge a patient for health care in excess of . . . the rate selected by the applicable State authority."[305] Under this bill, the maximum allowable price charged to uninsured or out-of-network patients would be left up to the State to pick between (1) 125% of the Medicare allowable charge (with some exceptions up to 200% in rural areas) or (2) "80[%] of the usual, customary and reasonable charge for the service, as determined by a database of usual, customary, and reasonable charges chosen by the applicable State authority."[306] "[R]educing the potential financial benefit to providers of remaining out-of-network" may also encourage more

302. Allison Inserro, *Coalition Agrees on Need To Protect Patients from Surprise Medical Bills,* AJMC NEWSROOM (Dec. 10, 2018), https://www.ajmc.com/newsroom/coalition-agrees-on-need-to-protect-patients-from-surprise-medical-bills [https://perma.cc/X2QD-2ZB9] ("The organizations include America's Health Insurance Plans (AHIP), American Benefits Council, Blue Cross Blue Shield Association, Consumers Union, the ERISA Industry Committee, Families USA, the National Association of Health and of Underwriters, the National Business Group on Health, and the National Retail Federation.").

303. *Id.*

304. Reducing Costs for Out-of-Network Services Act of 2018, S. 3541, 115th Cong. § 2729 (2018) (available at https://www.congress.gov/115/bills/s3541/BILLS-115s3541is.pdf [https://perma.cc/XGE9-KGBX]); Press Release, Maggie Hassan, *supra* note 295.

305. S. 3541 § 2(a).

306. *Id.*

providers to join insurers' networks, thereby also reducing out-of-network surprise bills.[307]

Another proposed bill, the "No More Surprise Medical Bills Act of 2018" introduced by Senator Margaret Wood Hassan in October 2018,[308] likewise would place a cap on hospital chargemaster pricing by "prohibiting hospitals and providers from charging [patients with medical emergencies] more than the in-network amount."[309] The bill states that "in [the] case of same-day emergency services," an "out-of-network provider may not charge the [patient] more than the amount that the [patient] would have been required to pay" if the patient were in-network.[310]

Another proposal in the discussion phase would place a ceiling on hospital bills based upon usual and customary rates for some out-of-network patients.[311] The discussion draft of the "Protecting Patients from Surprise Medical Bills Act" prohibits providers from "balance bill[ing] the patient for amounts beyond the cost-sharing amount[s]" allowed by the bill, which are based on average amounts and "usual, customary, and reasonable rates."[312] The bill places a ceiling on hospital charges that does not include chargemaster charges in the equation. Instead, the bill uses landmarks like the "median in-network amount negotiated by health plans and health [insurers]" and "125[%] of the average allowed amount for all private health plans" to provide for state based "benchmarking" of medical bills.[313] Chargemaster charges are not a part of the benchmarking equation in this proposal. The bipartisan Act "would regulate 3 areas: emergency services provided by an out-of-network provider in an out-of-network facility, nonemergency services following an emergency service from an out-of-

307. Loren Adler et al., *Analyzing Senator Hassan's Binding Arbitration Approach to Preventing Surprise Medical Bills*, HEALTH AFF. BLOG (Oct. 18, 2018), https://www.healthaffairs.org/do/10.1377/hblog20181017.792315/full/ [https://perma.cc/K55B-RPR9].

308. S. 3592, 115th Cong. (2018).

309. Press Release, Maggie Hassan, *supra* note 295.

310. S. 3592 § 2(a); Inserro, *supra* note 302 ("In emergency situations, out-of-network healthcare providers would not be able to charge patients more than they would have otherwise been required to pay if the bill had come from an in-network provider.").

311. A Bill to Prohibit Surprise Medical Billing of Patients, S. __, 115th Cong. (Discussion Draft 2018) https://www.cassidy.senate.gov/imo/media/doc/Discussion%20Draft-%20Protecting%20Patients%20from%20Surprise%20Medical%20Bills%20Act.pdf [https://perma.cc/FS6N-53XZ] (sponsored by Senators Bill Cassidy, MD, R-Lousiana; Michael Bennet, D-Colorado; Chuck Grassley, R-Iowa; Tom Carper, D-Delaware; Todd Young, R-Indiana; and Claire McCaskill, D-Missouri).

312. *Id.*

313. *Id.*

network facility, and nonemergency services performed by an out-of-network provider at an in-network facility."[314]

At least one expert agrees with the idea of placing ceilings on chargemaster prices saying: "Putting regulatory ceilings on permissible negotiated rates, targeting particular institutions for oversight, and implementing a range of 'pro-competition' regulatory provisions—e.g., prohibiting anti-competitive terms and conditions in insurer-provider contracts—deserve consideration."[315]

For instance, putting a Medicare-based ceiling on chargemaster charges might work because Medicare rates are readily available, so setting a maximum price based on Medicare rates would be an easy and transparent calculation; for example, a law could prevent hospitals from charging more than 300% of Medicare rates.

Another idea worthy of consideration to protect patients from predatory hospitals during emergency care is to simply add a "reasonable" requirement to all hospital charges related to care covered by the Emergency Medical Treatment and Labor Act (EMTALA).[316] "Reasonable" charges could be defined using one of the measuring sticks already discussed in this article. EMTALA already requires hospitals to provide an emergency screening examination and provide stabilizing treatment before transferring any patients. Simply adding a provision to EMTALA that all emergency care and stabilizing treatments must be billed at a rate such as 125% of the Medicare allowable rate would help protect patients from financial ruin related to unfair chargemaster pricing during emergencies. While direct rate setting may be too far, regulations placing limits on chargemaster rates seems like a reasonable place to start.

2. Establishing independent pricing dispute resolution options

Another approach advocated by some leaders is to establish more independent pricing dispute resolution options. For examples, S. 3592 includes an independent dispute resolution process using entities experienced in arbitration to resolve payment disputes with out-of-network providers—basically setting up a binding arbitration method to handle pricing disputes.[317] The arbitration process is set up so that the "insurer and provider each make

314. Inserro, *supra* note 302.

315. Berenson, *supra* note 288.

316. *Emergency Medical Treatment & Labor Act (EMTALA)*, CTRS. FOR MEDICARE & MEDICAID SERV., https://www.cms.gov/regulations-and-guidance/legislation/emtala/ [https://perma.cc/7FJZ-TBTP] (last modified Mar. 26, 2012, 8:43 AM).

317. Adler et al., *supra* note 307.

a final offer and an independent arbiter contracted by [the] government then chooses which of the two options it considers more reasonable."[318] The results of the arbitration are to be made public to help establish expectations for similar situation in the future—and hopefully help the future parties resolve the disputes prior to arbitration.[319]

In addition, "the legislation provides guidance to the independent arbiter to consider the relevant Medicare payment rate and the local average in-network rate, in addition to the level of training of the physician and complexity of the service, when determining which offer to select," and the "bill makes *no reference* to provider billed charges, which tend to be extremely high and are largely untethered from market forces." [320] Specifically, the bill lists the "factors" that the arbiter should consider in selecting the "more reasonable amount" including (1) "the average in-network payment rate for comparable items or services in the same geographic region," (2) "the level of training, education, and experience of the out-of-network health care provider," (3) "the circumstances and complexity of the particular dispute, including the time and place of the service," and (4) "the payment rate determined for the item or service under the original Medicare fee-for-service program under parts A and B of title XVIII of the Social Security Act."[321] Note that nowhere does the bill include the hospital's chargemaster charges in the equation.

Alternatively, under the proposal, each state could establish its own arbitration process "as long as the state process is equally protective and the arbitration results are made public."[322] Some states already have their own arbitration processes, including New York, New Jersey, Illinois, and New Hampshire.[323] As still another alternative, "states can elect a defined payment standard in place of the binding arbitration process, as long as it is no higher than 125[%] of the relevant Medicare rate or a comparable standard at the" HHS's Secretary's discretion.[324]

V. CONCLUSION

The spirit of "Your money or your life!"—a phrase linked with notorious British highway robbers (i.e., "highwaymen") of the sixteenth century—lives

318. *Id.*
319. *Id.*
320. *Id.* (emphasis added).
321. S. 3592, 115th Cong. § 4 (2018).
322. Adler et al., *supra* note 307.
323. *Id.*
324. *Id.*

on today in some hospitals' predatory admission contracts tied to unnecessarily ruinous chargemaster prices.[325] American courts and policymakers can do a better job of protecting vulnerable patients from predatory hospital pricing.

States courts and lawmakers should do more to protect patients from unfair chargemaster pricing. In settling disputes, courts should require "reasonableness" and fair market value for hospital services with a foundation in prices actually paid by government payers and insurers and should not consider hospitals' ethereal chargemaster windfall pricing in the equation. The Texas Supreme Court provides a landmark for other state courts where it notes "the *central issue . . . is what a reasonable and regular rate would be"* and "because of the way chargemaster pricing has evolved, the *charges themselves are not dispositive of what is reasonable . . . .*"[326] Admission contracts referencing unreasonable chargemasters should be ignored as unenforceable, unconscionable, "gun-to-the-head" adhesion contracts.

State policymakers should also act to protect vulnerable patients with fair pricing laws, limits on medical debt collection practices, and responsive avenues for complaint resolution. While state rate setting is likely too burdensome, states could place ceilings on hospital charges based upon Medicare rates or upon average amounts collected for specific services or one of the other methods described in this paper. States could also enact consumer protection laws with "price gouging" protections to protect patients facing personal health disasters similar to those protecting patients during natural disasters.

Federal courts and policymakers can likewise do more to protect patients from exploitation by excessive chargemaster pricing. First, hospitals with unfair chargemasters should lose their § 501(c)(3) nonprofit status because the windfall pricing actually increases the burden on government by bankrupting or financially devastating patients (i.e., making it more likely they will need government assistance) instead of providing a quid pro quo to offset the loss of tax revenue to the government. 26 U.S.C. § 501(r) provides a route for courts and government agencies to take away abusive hospitals' tax-exempt status, and in some cases, this has already happened—but more

325. BBC, *Highwaymen of the Peak*, BBC: INSIDE OUT (Sept. 24, 2014), http://www.bbc.co.uk/insideout/eastmidlands/series3/travellers_highwaymen_derbyshire_peakdistrict.shtml [https://perma.cc/GU64-TXH2] (describing the era of British highwaymen robbing vulnerable travelers during the 16th and 17th centuries with the average highwayman dying at the age of 28 "by hanging and then their bodies were hung in gibbets at crossroads as a warning to law breakers").

326. *In re* N. Cypress Med. Ctr. Operating Co., 559 S.W.3d 128, 133 (Tex. 2018) (emphasis added).

similar action is needed.[327] Victimized patients represent a protected class of persons who should take advantage of a potential implied right of action in § 501(r) to seek civil remedies against hospitals' unreasonable chargemasters as outlined in this article. Second, the discriminatory effects of unfair chargemaster pricing on minorities should be recognized as disparate impact discrimination and addressed by the OCR. In addition, individually affected patients may be able to take action under section 1557 of the ACA's "new, health-specific, anti-discrimination cause of action."[328] Third, federal agencies and state attorneys general should go after egregious hospital pricing using antitrust laws.

Federal policymakers should also act. Bipartisan leaders, researchers, and consumer groups agree that excessive hospital pricing should be addressed and that patients need the protections. Based upon the proposals outlined in this paper, there seems to be some agreement that ceilings need to be placed upon hospital chargemaster pricing—so agreeing on the location of that ceiling seems to be the key. Some multiple of Medicare rates or of fair market value based upon usual and customary reimbursement or on amounts actually paid by insurers seems like a potential landmark for agreement; given the commonalities of their proposals, the policymakers behind the current proposals should come together and combine their proposals into a single compromise bill that could likely get bipartisan support to provide some benchmarks for reasonable hospital pricing ceilings. In addition, providing victimized patients with an avenue for dispute resolution based in realistic pricing expectations should be included.

Excessive hospital pricing leads to unnecessary deaths and disability by discouraging vulnerable patients from seeking timely care. The public is worried about this issue, and lawmakers from both parties agree that action is needed. The time has come for state and federal courts and policymakers to end the era of the hospital highwaymen and finally lay these predatory wolves to rest.

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327. Epps, *supra* note 189; *see also*, Hooke, *supra* note 190; Greenwalt & Teaff, *supra* note 190; Wiik, *supra* note 191.

328. Rumble v. Fairview Health Servs., No. 14-CV-2037 (SRN/FLN), 2015 WL 1197415, at *11 (D. Minn. Mar. 16, 2015); Watson, *supra* note 234, at 864–70 ("Section 1557 of the ACA creates a new health-specific anti-discrimination prohibition that reaches further than Title VI, prohibiting discrimination not only in federally funded health programs but also federally administered health programs and new ACA-authorized entities like Exchanges.").